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Providing Services to Migrant Farmworkers

Special Supplemental Food Program for Women, Infants, and Children, and the Commodity Supplemental Food Program

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Acknowledgments

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The Supplemental Food Programs are open to all eligible people regardless of race, color, sex, national origin, age, or handicap.

Introduction

The first handbook on providing services to migrant farmworkers was distributed by the Food and Nutrition Service (FNS) in 1979. Since that time, significant progress has been made in the delivery of migrant services. FNS recognizes, however, the need for additional technical assistance in order to continue to improve the accessibility of the Special Supplemental Food Program for Women, Infants, and Children (WIC) and the Commodity Supplemental Food Program (CSFP) to migrant populations. Therefore, this updated handbook brings together all pertinent program information and compiles it into a single resource document. The handbook is intended to serve as a comprehensive guide for State and local agencies administering WIC and CSF programs in areas where migrant farmworkers are employed.

In addition, legislation which authorizes the WIC program, Public Law 95-627, requires USDA to report to the National Advisory Council on Maternal, Infant, and Fetal Nutrition on efforts to ensure, to the maximum extent possible, that WIC services are provided to members of eligible migrant populations as such persons move among States. Therefore, this handbook also serves as such a report.

The WIC and CSF programs are part of the complex of public programs serving migrants. It is the intent of the WIC and CSF programs to provide needy migrant families with some protection against inadequate nutrition as well as to provide access to health care. The continuation of WIC or CSF program benefits to this population as it migrates during the year is an important step towards improving the health status of many at-risk pregnant women and their children -- now and in the years to come. Such benefits can only be acknowledged if significant efforts are made to provide program benefits to needy migrants regardless of where they live and work.

With the lack of reliable, up-to-date data on the number of migrant farmworkers presently living and working in the United States, it should be pointed out that the statistics and health data presented in this handbook may not be entirely reflective of the migrant population today. However, this information may support trends or problem areas that still exist and need continued attention to improve the accessibility of WIC and CSF programs to migrant populations. References cited in this guide are listed at the end of this section.

For the reader's convenience, this handbook has been prepared so that various topics stand on their own. While this has resulted in some repetition, it eliminates the necessity of having to refer back and forth to various sections for information.

Who They Are

The labor of migrant farmworkers is a vital component of agricultural productivity and the economy of the United States. A large number of farms and canning factories depend on migrant labor each year to harvest crops and work in food processing plants. While in the past decade mechanization has decreased the need for some migrant labor, many crops can only be harvested by field workers. Migrants are also utilized in plants that produce cardboard boxes to ship produce that other migrants are harvesting, to drive trucks, and to do nursery/landscape services.

Despite the contributions made by migrant farmworkers to the national economy and food supply, the special needs of migrants and seasonal farmworkers and their families pose unique challenges to service agencies. The changing composition of the migrant farmworker population, due to international political and economic situations such as the influx of Central Americans, has added uncertainty to health planning and forecasting. (Wilk, 1985)

Migrants have historically suffered from low wages, difficult working and living conditions, and the lack of continuous and adequate health and social services, and education. Migrant families, consequently, suffer from the typical symptoms of chronic poverty -- being undernourished, undereducated, poorly housed, and receiving minimal health care. While not all migrant farmworker families face poverty conditions of this nature, a majority do.

Although the problems facing the migrant population have received national attention over the years, further work is needed to eradicate the problems. The Report of the Task Panel on Migrant and Seasonal Farmworkers presented to the President's Commission on Mental Health in 1978, concluded that despite efforts over the past 15 years American farmworkers and their families often still live and work under conditions which are below standard. This is still true today. According to a 1984 survey, many migrants are still subject to third world health and sanitary conditions. (Trotter, 1984)

Efforts to remedy the plight of this segment of the population have been hampered to some extent by the lack of reliable data on the actual number of migrants presently in the United States. Estimates of this population vary from 226,000 to 1.5 million. A legal services corporation study (Lillesand et al., 1977) used Federal and State data and estimated that there were about 1.5 million migrant farmworkers, including dependents; the Office of Migrant Health (U.S. Department of Health, Education, and Welfare (DHEW), 1975) estimates that there were about 700,000 to

750,000 migrant farmworkers, including dependents; and the U.S. Department of Agriculture, Economic Research Service (ERS) 1983 data estimates 226,000 migrant farmworkers. ERS states that undocumented workers could greatly increase that number. The WIC program reports serving approximately 330,000 migrants (women, infants and children up to age 5) in 1985. These statistical variations are the result of the lack of a uniform definition of a migrant.

Characteristics

The migrant population is composed of many different ethnic groups including Whites, Blacks, American Indians, Hispanics, Southeast Asians, Central Americans, Haitians, Puerto Ricans and Jamaicans.

According to 1983 ERS data, 45 percent of the migrants were White, 16 percent were Hispanic, and 39 percent Black and others. The majority were White males under 25 years of age. Thirty-nine percent of the migrants worked fewer than 75 days a year at farmwork; 27 percent worked 75 to 149 days; and 34 percent worked 150 days or more. Migrant farmworkers earned an annual average income of $5,291, and farmwork accounted for $4,638 of that amount.

Also according to 1983 ERS data, about 15 percent of all migrants 25 years and older had completed high school, and about 13 percent of these graduates had some college education. However, many migrants had relatively low levels of education. Fifty-seven percent had less than a ninth grade education and 12 percent were classified as functionally illiterate, having attended fewer than 5 years of school.

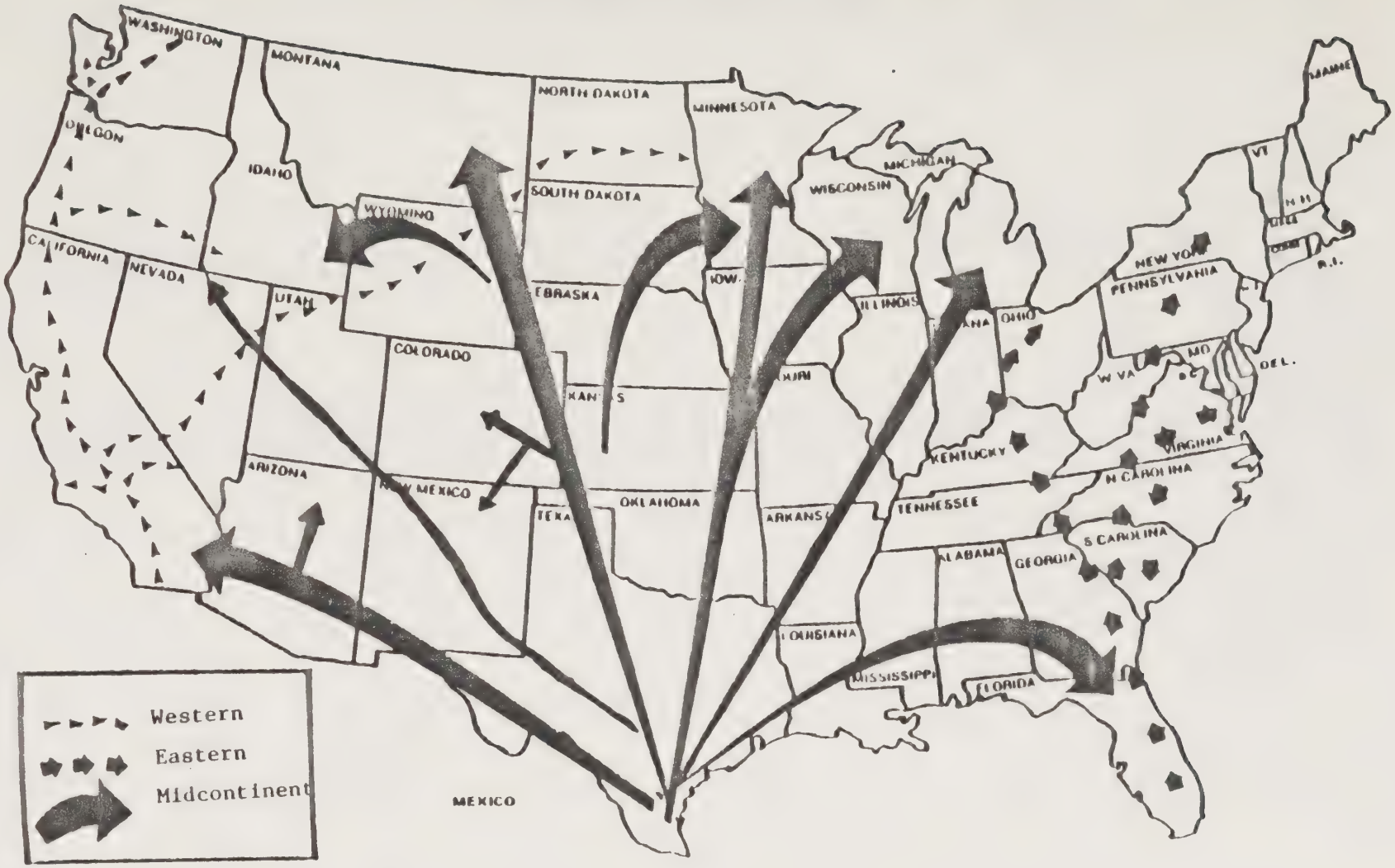
Migratory Streams

Lifestyles of migrant farmworkers are characterized by travel from one agricultural area to another throughout the growing season. Migrants may work away from their homes 4 to 8 months a year, and often travel with their families (including members of their extended families), or as single male groups. Some workers are recruited at their homebase areas by crewleaders and then travel instream in groups for work.

Those who migrate in pursuit of work historically have traveled in three "mainstreams" -- the west coast, midcontinent, and east coast. The west coast stream originates in Texas and flows up through California to the Pacific Northwest; the midcontinent stream starts primarily in South Texas and extends northward with the majority of workers going to Michigan, Ohio, Indiana, Illinois, Iowa, Minnesota and other midwestern States; and the eastern stream goes from Florida northward along the eastern

seaboard. Advanced agricultural technologies and competition for available work have altered traditional migratory patterns in recent years. Midwestern stream and coastal migrants now mingle in new patterns. Also, significant changes have occurred in the western stream, and California now serves as a year-round location for resident seasonal workers. The same is true of Florida. The map on the following page illustrates recent agricultural migration patterns.

THE MAJOR MIGRANT STREAMS



Migrant Participation in WIC

Charts on the following pages depict migrant participation in the WIC program for fiscal years 1982-1985. Figures include women, infants, and children.

Migrant participation information is not available for CSFP.

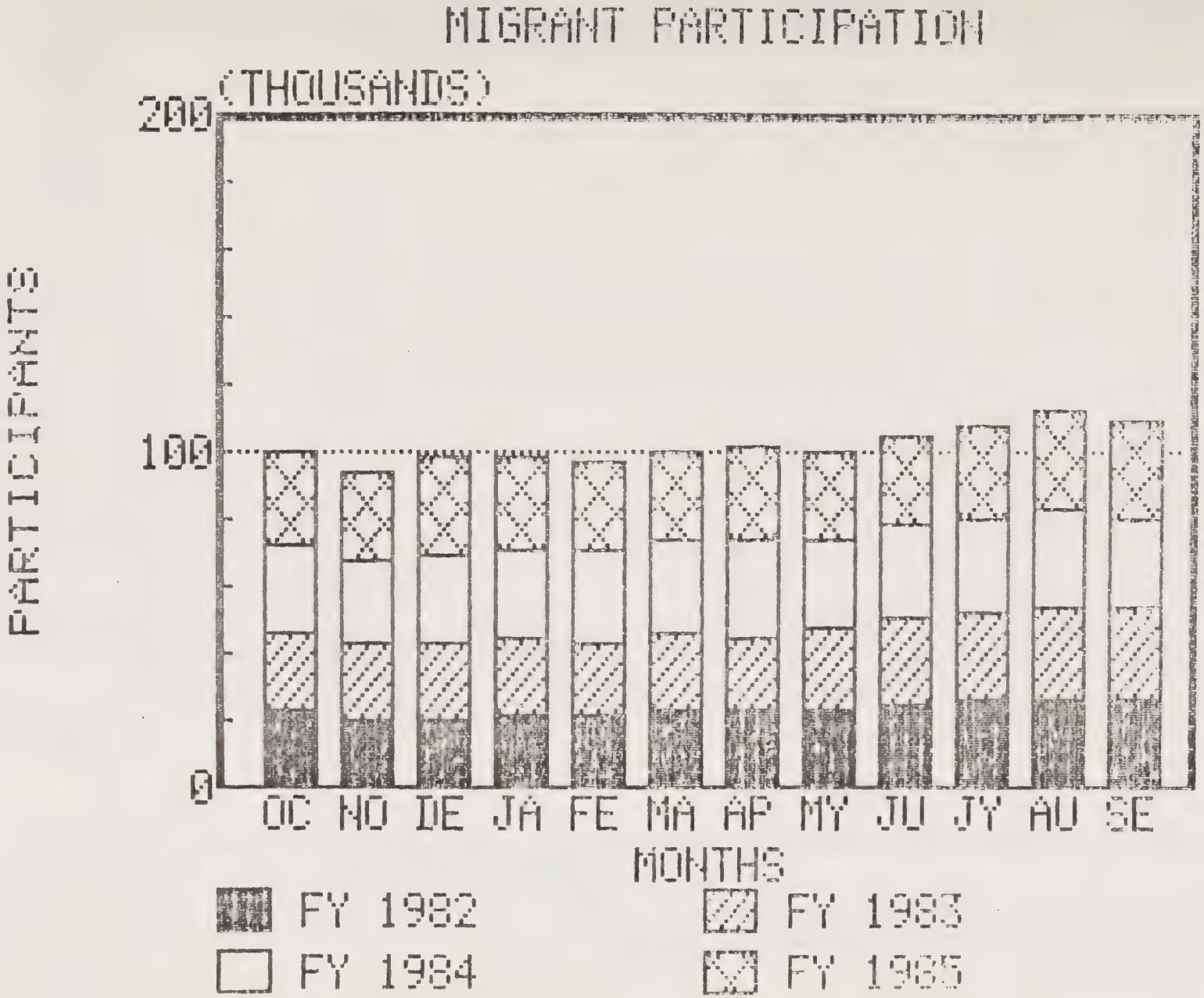
MIGRANT PARTICIPATION BY STATE (Fiscal Years 1984 and 1985)

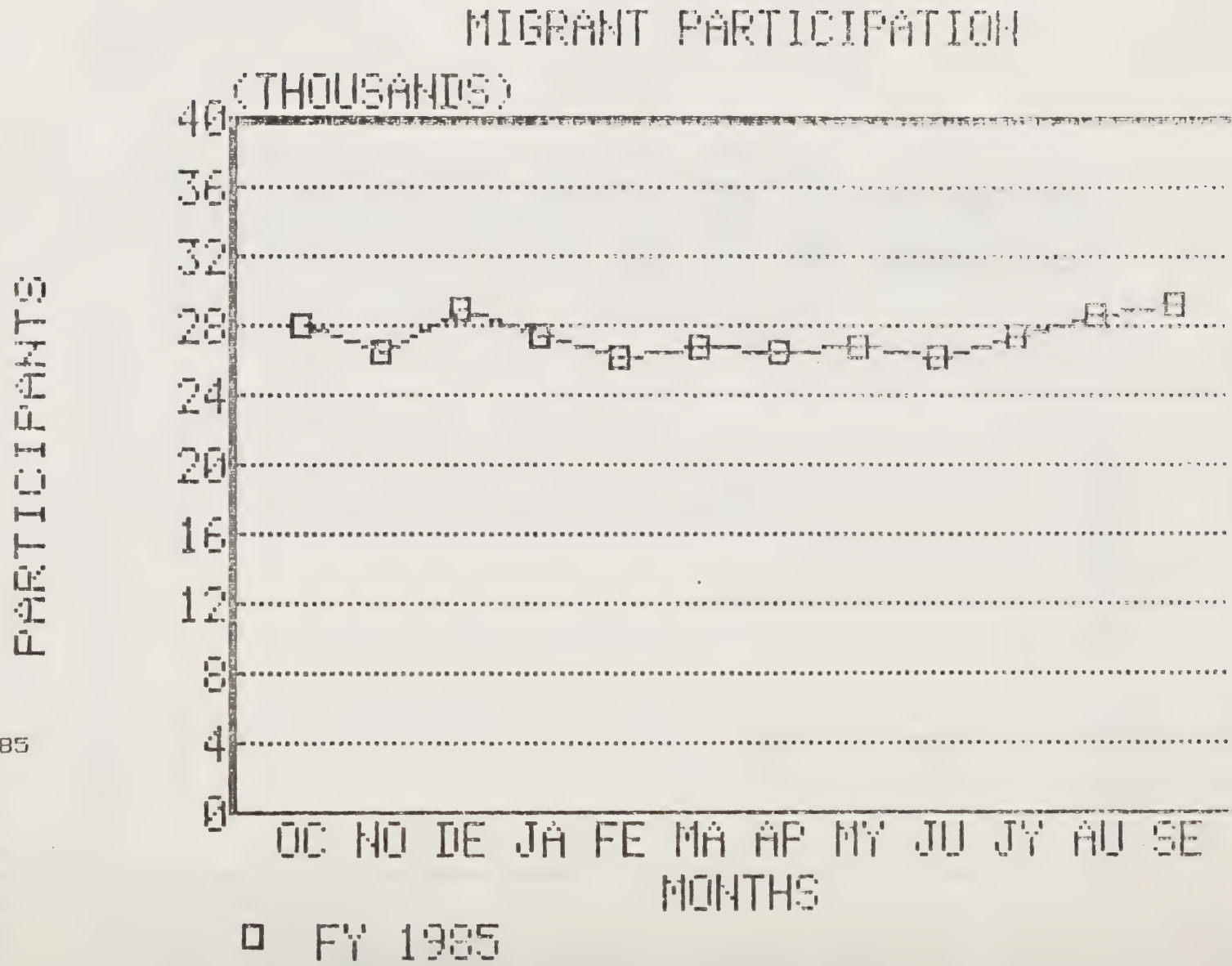
	Participation		Percent Change	
	FY 84	FY 85	Increase	Decrease
Alabama	267	339	27.0	
Arizona	94	941	901.1	
California	83,800	93,428	11.5	
Colorado	2,545	2,722	7.0	
Delaware	412	70		83.0
Florida	66,894	69,007	3.2	
Georgia	1,051	1,483	41.1	
Idaho	3,571	3,504		1.9
Illinois	2,014	1,848		8.2
Indiana	1,153	1,561	35.4	
Iowa	449	555	23.6	
Kansas	1,910	1,823		4.6
Louisiana	66	43		34.8
Maryland	36	a]		
Michigan	15,585	18,993	21.9	
Minnesota	2,495	1,160		53.5
Montana	244	174		28.7
Nebraska	2,106	1,095		48.0
New Jersey	608	1,009	66.0	
New Mexico	218	433	98.6	
New York	1,888	2,130	12.8	
North Carolina	5,327	5,838	9.6	
North Dakota	947	1,246	31.6	
Ohio	3,651	3,412		6.5
Oregon	7,558	6,743		10.8
Pennsylvania	1,959	2,162	10.4	
South Carolina	1,166	1,089		6.6
South Dakota	56	57	1.8	
Tennessee	310	298		3.9
Texas	85,619	77,101		9.9
Utah	428	800	86.9	
Virginia	2,155	2,302	6.8	
Washington	26,628	24,847		6.7
West Virginia	522	481		7.9
Wisconsin	1,599	1,405		12.1
Wyoming	304	202		33.6
TOTAL	325,635	330,301	AVERAGE CHANGE:	1.4% increase

a]: Migrant participation was not reported for Fiscal Year 1985.

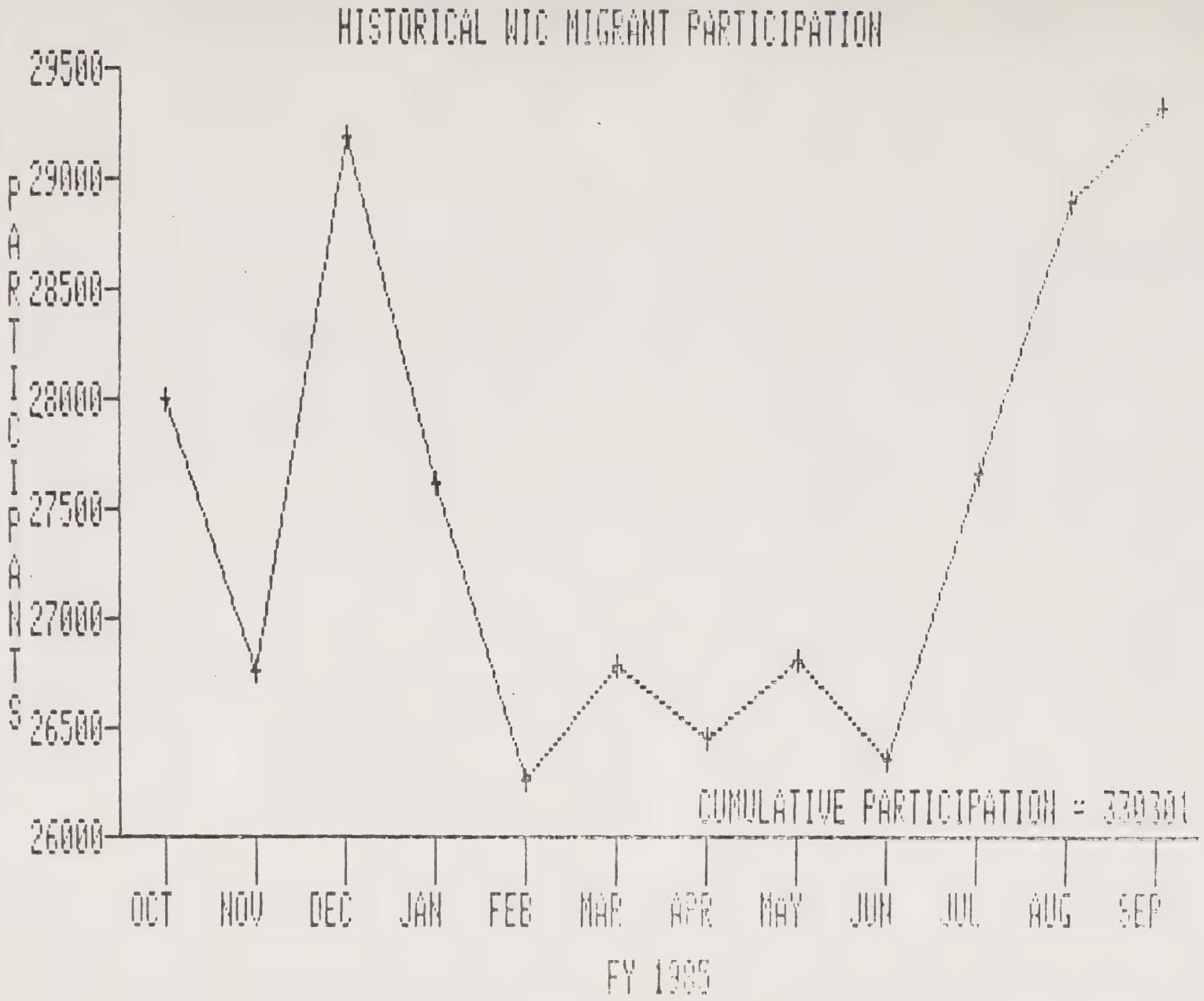
HISTORICAL WIC MIGRANT PARTICIPATION
MONTHLY TRENDS

	FY 1982	FY 1983	FY 1984	FY 1985
OCTOBER	23623	23978	25865	28016
NOVEMBER	20257	23105	25321	26766
DECEMBER	20899	23273	25908	29209
JANUARY	21732	23626	26286	27639
FEBRUARY	21780	22772	26513	26285
MARCH	24474	23164	26298	26802
APRIL	23590	22558	29174	26467
MAY	24521	23640	26522	26816
JUNE	26020	25398	27699	26373
JULY	26971	26551	28233	27675
AUGUST	27104	27988	29086	28907
SEPTEMBER	26860	27817	28730	29346
AVERAGE MONTHLY PARTICIPATION	23986	24489	27136	27525


MIGRANT PARTICIPATION
(THOUSANDS)
200
100
0
PARTICIPANTS
OC NO DE JA FE MA AP MY JU JY AU SE
MONTHS
FY 1982
FY 1983
FY 1984
FY 1985



	FY 1985
OCT	28016
NOV	26766
DEC	29209
JAN	27639
FEB	26285
MAR	26802
APR	26467
MY	26816
JUN	26373
JY	27675
AUG	28907


HISTORICAL WIC MIGRANT PARTICIPATION
PARTICIPANTS
29500
29000
28500
28000
27500
27000
26500
26000
CUMULATIVE PARTICIPATION = 330301
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
FY 1985

Specific Health Problems of Migrant Farmworkers and Their Families

Various studies/reports on migrant farmworkers have documented the following conditions:

- the infant mortality rate for migrants is 125 percent higher than the national average (DHEW Contract, 1977);

- the rate of parasitic infection among migrants is estimated to be 11 to 59 times higher than that of the general U.S. population (Ortez, 1984);

- migrant women deliver their babies out of hospitals at a rate nine times the national average (Goodson, 1980);

- migrants are hospitalized for accidents at twice the national average; the migrant death rate from accidents is 300 percent above the national average (Shapiro and Foster, 1980);

- incidence of malnutrition among migrants is higher than any other subpopulation in the country (Goodson, 1980) and;

- the life expectancy of a migrant farmworker is 49 years as compared to the national average of 70 years (DHEW Contract, 1977).

These statistics present a compelling picture of migrants as an extremely high risk group. The economics of the farmworker's way of life is partially responsible for poor health. Often the migrant earns his/her "annual" salary in just a few months' time. Taking time off for health care is "lost" annual income. Wilk (1985) states that the majority of migrants and their families seek medical treatment for emergency or acute conditions, rather than for chronic conditions or for preventive health services (e.g., checkups or immunizations).

The health of migrants is also threatened by their living conditions. Housing for migrant farmworkers is often inadequate to accommodate large families and may lack the basic essentials for a healthy living environment. "Home is often a barracks without toilets, cooking facilities, or sanitary water." (Rosenthal, 1978) Whatever the type housing, it usually is scarce; migrants sometimes even live in their vehicles or camp out in fields, by rivers, and under bridges.

Agricultural workers are the only occupational group in the United States who are not protected by Federal rules regarding sanitary facilities and drinking water provided at the worksite. Migrant and seasonal farmworkers are at increased risk of contracting sanitation-related illnesses because of the lack of toilets, handwashing facilities, and potable drinking water at the worksite. A basic principle of public health is that poor hygiene causes illness. (Summary Report, Wilk, 1985)

Many specific health problems were revealed by a nutrition survey of migrant workers in southern Florida (Kaufman et al., 1973) and various other studies for populations which were not strictly migrants in California (Bruhn and Panghorn, 1970; and Acosta et al., 1974), Texas (Burroughs and Huenemann, 1970; and Larson et al., 1974), and Colorado (Chase et al., 1971). Information published by Trotter (1984), Wilk (1985), and Johnson (1985) provides even more recent data on the health of migrants. According to Wilk (1985), the health problems most frequently reported at migrant health clinics include dermatitis, injuries, respiratory problems, musculoskeletal ailments, and eye problems. Some of the migrant health problems are discussed in the following:

Dental

Dental problems are particularly critical among migrants because dental care is usually sought only in emergencies. A high prevalence of dental caries has been found in all migrant farmworker populations, especially in the children. Dental disease is one of the most prevalent nutrition-related diseases. Little corrective or preventive work is done. Periodontal disease is also highly prevalent in children and in almost all adults (Baumslag and Roesel, 1979). Trotter (1984) also points out that dental caries remain one of the most common health problems of migrants.

Nutritional Deficiencies

Vitamin A deficiency is the most prevalent vitamin deficiency in the migrant population. Fifty-five percent of the migrant farmworker population in Colorado had less than acceptable serum vitamin A values; 20 percent below 20 mcg., the level at which night blindness is usually detectable (Chase et al., 1971). Over 30 percent of children in Texas clinics had levels below 20 mcg/100 ml. In Florida, vitamin A deficiency was less prevalent (2 percent). Dietary histories indicated low median intakes in all areas except California (Burroughs and Huenemann, 1970). Although vitamin A deficiency was rarely associated with clinical symptoms, a strong correlation between vitamin A deficiency and upper respiratory tract and skin infections was found (Chase et al., 1971). A deficiency of vitamin A in Mexican-Americans may be partially attributable to low intakes of leafy green and yellow vegetables (Larson et. al., 1974; Kaufman et al., 1973).

Riboflavin deficiencies were common in all areas except California, and more so in Blacks (15 percent) than Mexican-Americans (9 percent); however, deficiencies varied by year in Texas from 8 to 22 percent (Larson et al., 1974).

Vitamin D deficiency was diagnosed by rib-bending (8 percent) and widened wrists (22 percent) in Texas (Larson et. al., 1974).

In Colorado, only 10 percent of the mothers gave vitamins or iron to their infants in the first 6 months of life. Larson indicated that most mothers believed vitamins and minerals were only obtained from pills and not from foods. Young infants and children up to age 5 were frequently found to have low iron intakes and, consequently, deficient hemoglobin and hematocrit concentrations. Their mean dietary intakes of iron were consistently reported to be low, ranging from 5-7 mg/day (Kaufman et al., 1973) to 7.3 mg/day (Larson et al., 1974). The Recommended Dietary Allowances (RDA) for children are considerably higher: 15 mg/day for 12-47 month olds and 10 mg/day for 48-71 month old children. Over half the children in the Burroughs' study (1970) were deficient in hemoglobin (less than 10 mg/100 ml). Acosta (1974) also found that 86 percent of 1 to 2 year olds and over 50 percent of children less than 4 years old receive less than two-thirds of the RDA for iron.

Also according to Trotter (1984) anemia in migrants is one of the current health problems most frequently found by health providers.

Growth Patterns for Children

Standards used for growth failure differed between surveys conducted in Florida, California, Texas, and Colorado. Kaufman (1973) showed that Mexican-American children have a higher prevalence of low weight and low height for age than Blacks. Chase (1971) found a significant number of children between the third percentile indicating extensive undernutrition. Kaufman (1973) also showed that in the first year of life a large proportion (37 percent) of infants in Florida migrant camps were below the 15th percentile of weight for age based on the Stuart Meredith Standards; Mexican-American female infants were consistently underweight for their age; and a statistically significant percentage of migrant children were short for their age, especially the Mexican-Americans.

High Risk Pregnancy

"The nature of agricultural work and the physiologic changes during pregnancy put the pregnant farmworker at increased high risk of health problems for both her and her baby. Occupationally caused fatigue has been associated with prematurity. Pesticides may cause genetic damage, miscarriage, cancer, birth defects, or neurological or behavioral ill effects. The risk of heat stress is heightened during pregnancy as is the risk of infection and respiratory problems. Musculoskeletal changes occur as the fetus grows and the woman's center of gravity changes, increasing the risk of falls. The lack of toilets in the fields increases the probability of urine retention, which leads to urinary tract infections. Urinary tract infections during pregnancy have been linked to higher rates of premature birth and perinatal death." (Wilk, 1985)

Increased Susceptability to Infections

"Migrant and seasonal farmworkers are susceptible to numerous infectious diseases. The lack of proper sanitary facilities in the home and in the workplace contributes to the spread of such diseases.

"Diseases related to poor sanitation include dysentery, hepatitis, typhoid fever, and other respiratory and intestinal ailments. Diseases commonly spread by using the same eating and drinking utensils, drinking non-potable water -- potable water being unavailable -- and fecal-oral contamination from the lack of toilet and handwashing facilities. (Since many crops are packaged directly in the fields, and some disease organisms (e.g., parasite eggs) are very hardy, washing the produce may not remove these organisms. The potential exists for contamination of crops and the transfer of diseases to the consumer.)

"Poor sanitation contributes to a variety of health problems, including high rates of parasitic infections such as bacterial, protozoan, viral, and worm infections. The few extant studies of migrant farmworker children and adults show them to have higher rates of parasitic infections than either the general U.S. population, or even other rural or poor urban populations.

"Untreated parasitic conditions can lead to chronic anemia or malnutrition in both children and adults. The effects of parasitic infections on the human fetus are not fully understood, but low birth weight may well be one result.

"Worm infections also create serious health hazards; barefoot farmworkers and children are at risk of contracting worm infections in areas where human or animal excrement is not properly disposed." (Report Summary, Wilk Study, 1985)

Lead Poisoning

In 1983 the National Indian Health Board (NIHB) Science Center at Colorado State University, Fort Collins, Colorado announced a new culture-bound syndrome of lead poisoning from two folk remedies used by Spanish-speaking persons, including migrants (adults and children). The two powdered remedies in question are known as Azarcon and Greta. Azarcon is pure lead tetroxide; Greta is almost pure lead monoxide or lead dioxide. Poisonings have been reported in California, Colorado, New Mexico, Michigan, and possibly Texas.

Information released by NIHB reveals that Mexican-Americans are using these substances to treat an intestinal condition called "empacho." "Empacho corresponds to the belief that a blockage exists in the intestine. Because Azarcon and Greta are purgatives, or substances that induce diarrhea, they are thought to free the body of the blockage. The lead in the powders accumulates in the body and can be very dangerous, particularly if it gets stored in the brain. Continued use of the folk remedies could lead to brain swelling, mental retardation or death."

NIHB information states that the exact dose is difficult to estimate. "The 'tip of the pinkie' is a term often reported. It would be appropriate to assume that each dose is approximately 300-500 mg of elemental lead. Larger doses ranging up to a teaspoon have been mentioned. Such a dose would easily be 10,000 mg of lead. Azarcon and Greta are given dry, mixed with sugar as a suspension in tea, or mixed in olive oil...

"Although in many areas it is said these substances may be used only once, chronic use has been noted in most cases thus far detected. Because the symptoms of lead poisoning are similar to the symptoms for empacho, it is particularly of concern that Azarcon and Greta will be given for the symptoms of lead poisoning."

Mental Development

Severe malnutrition during prenatal life and/or infancy in man has been shown to significantly decrease the number of brain cells (Read, 1973). The smaller the infant at birth the more severe the effect on ultimate brain cell numbers (Winick, 1973). It has also been reported that infants in the United States who were severely malnourished early in life consistently performed poorly when tested at a later age (Chase et al., 1971). Severely malnourished children show behavioral changes manifested as a lack of normal curiosity and desire for exploration that is natural in a young child (Cravioto et al., 1966).

Social deprivation and malnutrition, conditions which have been shown to exist in the lifestyle of migrant workers, are frequently associated with mental retardation (Cravioto et al., 1966). Migrant children have the lowest educational attainments of any group in the nation. They enter school later, show greater retardation, and constitute the largest single reservoir of illiteracy (Laughlin, 1978).

Pica

Pica (craving and excessive ingestion of non-food substances such as clay, ice, or starch), a practice sometimes associated with dietary inadequacy, is relatively common with pregnant women in the migrant population. This condition is often associated with iron deficiency and has been associated with lead poisoning. Sixteen percent of the mothers in a Texas study reported eating clay, dirt, or other non-foods. Thirty-eight percent of the northern California migrant population reported pregnant women who ate dirt or laundry starch (Bruhn, 1970 and Larson et al., 1974).

Pesticide Poisoning

Pesticides, which are absorbed by the human body through the skin, lungs, and mouth, cause health problems, including serious poisonings and death. Farmworkers are exposed to pesticides in a variety of ways including: accidental spraying of workers; indirect spraying from drift carried by the wind; residue on plants; eating, smoking, going to the bathroom with contaminated hands; and eating/drinking contaminated foods/water. (Wilk, 1985)

The following are excerpts from "A Guide to the Development of a Pesticide Health Hazard Management Program" published by DHHS in 1982:

"Migrant agricultural labor is seasonal work. There are peak times for planting and harvesting and therefore a seasonal fluctuation of risks for pesticide poisoning for migrants. The highest percent of occupational pesticide poisonings occurs in June, July, and August, with the greatest percentage of incidents in July...

"Pesticides are toxic substances deliberately introduced into the environment to control undesirable organisms such as insects, weeds, rodents, and fungi...

"The Office of Pesticide Programs of the Environmental Protection Agency conducted a national study from 1971-73 and 1974-76, and documented 3,000 cases of pesticide poisonings which required hospitalization. Other studies have found that physicians treat many outpatient cases of pesticide poisonings for every case requiring hospitalization...

"There are many problems, however, with data on the number of pesticide incidents. Many cases of pesticide poisonings do not enter the health care system, are not recognized or diagnosed, or are not reported...

"Exposure and poisoning from pesticides also occur in non-work settings. Families of farmworkers are exposed frequently to pesticides through workers' contaminated clothes and both full and empty pesticide containers. Children are especially vulnerable. The Texas 1980 Pesticide Incident Summary, presenting data compiled from five States, showed that children under five years of age were noted in 1,440 episodes (68.5 percent) and in 15 intoxications (30 percent). Many incidents arise from careless storage or disposal or improper use of hazardous chemicals. Children, whose bodily systems are not fully developed and who, in migrant families, often suffer from malnutrition, are the group at greatest risk of accidental poisoning from pesticides in the non-work setting."

Existing literature links pesticides with a range of acute chronic effects. These include cancer, birth defects, genetic damage, neurological, psychological and behavioral effects, blood disorders, sterility, menstrual dysfunction, abnormalities in liver and kidney function, and dermatitis. (Wilk, 1985)

Other Occupational Hazards

In addition, migrant farmworkers encounter other occupational hazards, such as the following:

- heat-related illness such as heat stroke, heat exhaustion, or heat cramps;
- noise pollution from loud machinery;
- vibration from machinery power tools, and rough terrain;
- dermatitis resulting from reactions to chemicals and plants; and
- orthopedic musculoskeletal problems resulting from heavy lifting and carrying, and difficult work positions;
- eye injuries from twigs, branches, and pesticides;

- acute upper respiratory tract infections from breathing pesticides; and

- accidents (such as fractures or sprains from falls from ladders or equipment; amputations and lacerations from machinery; bones and joints crushed by tractor/truck accidents; and electrical from hitting power lines).

Factors Hindering Delivery of Services to Migrants

The mobility, poverty, and substandard living and working environments experienced by many migrants make their receipt of continuous health and social services essential. Unpredictable income and low wages often make it difficult for some migrants to provide their families with everyday necessities. Consequently, their needs for food stamps, WIC and CSFP, health care and other health and social services are immediate.

However, a variety of barriers impede receipt of these services. Many of the barriers are the result of occupational mobility, isolation, precarious employment, and economic situations. Other barriers can result from unresponsive communities, discrimination and legislative restrictions such as stringent eligibility criteria, and waiting periods.

Specific factors that present barriers are:

Type of Communities

Communities to which migrants travel are generally rural, small, and supported primarily by agriculture. Consequently, migrant farmworkers are subjected to the problems frequently inherent in any rural community (e.g., shortage of health providers, lack of medical facilities and equipment, limited health care and minimal or no public transportation system).

Language

Difficulties in receiving "in-stream" assistance are further multiplied by the fact that many migrants speak little or no English. The communities to which they migrate often lack interpreters and bilingual outreach information, resulting in further isolation of the migrant family.

Transiency

The continual move from area to area creates major problems for many migrant families. Even if they have managed to receive benefits in one community, they may find that they cannot continue to receive those same benefits in another area. Migrant families also often face difficulties in locating such services in a new and unfamiliar locale. Such mobility isolates migrants from traditional health care. Additionally, some communities and agencies refuse to accept the responsibility for serving migrants simply because they lack permanent residency. Migrants are often in an area for a short time, and if there is no work or a crop failure, they quickly move on without stopping to obtain services, especially since they are unfamiliar with the location of the various agencies.

Camp Setting

Another consideration is the migrant camp setting which, in itself, can impede service delivery. Some migrants travel in crews, arriving in an area by prior arrangement just at the time their labor is needed, and leaving shortly thereafter. Not all members of such a group have access to transportation except that provided by a crew chief. Another common problem migrants face is coping with clinic hours that do not coincide with the camp work routine. A family may work in the fields all day and by the time they are finished with their day's work, the agency has already closed.

Working Conditions

"In no other labor system known in contemporary America does any set of supervisory individuals have such virtually unrestrained control over the lives of others. While an unknown number of farmworkers contract directly with the grower or food processor for their labor, the great majority of farmworkers do not directly control the conditions of their work. Instead, their services are contracted for by a crewleader. The crewleader's business is to recruit and frequently to transport farmworkers from their homebases to areas where agricultural laborers are needed. Some operate interstate recruiting services in homebase States such as Florida and Texas. Others work exclusively or primarily within the boundaries of a single State, recruiting migrants, seasonal farmworkers, and day-haul crews. Crewleaders are the middlemen between the grower and the farmworker; as such intermediaries, they not only recruit and transport workers, they also act as supervisors as well, and often handle all arrangements for payment to the worker. Because of their dependency on the crewleader for employment, farmworkers are especially vulnerable to exploitation by irresponsible crewleaders." (Report of the Task Panel, 1978)

The attitudes of some crew chiefs and camp managers often hamper the delivery of WIC and other health and social benefits, or even the distribution of outreach materials in migrant camps. It has been pointed out that sometimes these individuals fear that migrants will take time from work to seek program services, or that they "may get on programs and drop out of work." Since the growers control the housing and often own the labor camps, it is usually necessary for health and social service representatives to obtain their permission to go into the camps.

Migrant Resistance/ Perception

Some States report that migrants are somewhat reluctant to come into clinics that are not migrant health clinics. They may even lack general health knowledge and therefore do not seek routine health care. Migrants sometimes have a cultural bias against modern medicine and mistrust physicians; preferring to use root medicine and midwives. Migrants may perceive the WIC program as simply a food or welfare program, rather than a special nutrition program which also offers nutrition education. Some utilize the WIC program for short periods of time, but if their situation improves slightly, they may not return the next month.

According to Trotter (1984), migrants see the following as barriers to receiving health care:

- Loss of pay
- Amount of time it takes to get an appointment
- Unaffordable health care
- Distance to facility
- Child care unavailable
- Transportation unavailable
- Don't want to bother the doctor
- Don't know the doctor
- Don't believe in doctors (take care of own health)
- Can't speak English
- Afraid of what will be found
- Believe doctors are prejudiced
- Friends/relatives had a bad experience

Health Insurance

"Most migrant and seasonal farmworkers and their families cannot afford health insurance. In 20 States, farmworkers are not covered by workers' compensation, and even in States where they are covered, they often do not know -- and are not told -- that they can collect compensation for work-related injuries or ailments. When farmworkers retire or are disabled they may find that though they have worked a lifetime they are denied Social Security benefits. Employers may violate Federal or State laws that require them to report income for each worker rather than paying all income to the head of household." (Summary Report, Wilk, 1985).

Locating Migrants

Most States have cited problems with reaching small pockets of migrants sparsely scattered throughout the State. States have fewer problems finding migrants when there are large numbers concentrated in one area and when there is a strong local migrant council or farmworkers group present.

Suggested Techniques for Delivery of Services

To overcome barriers to migrant participation, the following suggestions are offered. The information provided under "State Agency Examples" was obtained from WIC State plans of program operation and administration, telephone contacts with WIC State and local agency personnel, FNS regional offices, and various reviewers of the draft of this handbook.

Public Notification

Effective public notification is vital to ensure that all potential migrant participants are aware of WIC and CSFP. Effective notification helps migrants overcome their geographic and social isolation from the main population. State and local agency administrators must often go to the migrants since migrants follow crops, not programs.

Exchange of Information with Other Programs/Organizations

The results from the evaluation of the FNS WIC Migrant Demonstration Project in 1978 showed that the most effective WIC public notification among migrants is achieved through cooperation with other local programs serving farmworkers.

The following table from the evaluation shows responses from the participants when asked how they heard about the WIC program:

Source of Information	Percentage Response
Public clinic	38.8
Another migrant	29.6
Community worker	16.7
Farmworker organization	11.1
Private physician	7.4
An advertisement	5.5

The mutual cooperation and exchange of information between local programs serving farmworkers cannot be overemphasized. Local food stamp, employment, and labor offices should all be contacted and information shared regarding migrant activity in a particular area. Contacts like these can also develop into a referral system which will help ensure that migrants receive continuous program benefits. Since WIC/CSFP certification takes 10-20 days, local certifying agencies should be well linked to local emergency food programs. Other groups that should be included in referral network systems are health and medical organizations, hospitals, clinics, physicians, volunteer service organizations, social service agencies, religious organizations, and child care programs.

Local farmworker organizations are another important community resource in reaching migrant participants. One suggestion is that State or local agencies might contract with a farmworker organization for the purpose of hiring workers to promote public awareness of the program. This is particularly effective if these workers are members of the migrant community. Farmworker organizations are usually known by migrants. These organizations may also be willing to provide this service free.

At a minimum, farmworker organizations can provide information on when to expect migrants in a particular area, how many to expect, how long they will stay, and where they are likely to reside. In addition to local farmworker groups, some States have statewide farmworker organizations, a Governor's office on migrant affairs, or a migrant office in the State Department of Labor. Agencies or organizations that sponsor or service refugees can also be invaluable. State agencies should make every effort to encourage cooperative working relationships between local WIC and CSFP agencies and these various organizations.

Visit Campsites

If it is possible to gain access to the camps in the evenings, go knock on doors in the camps. Also, determine, if possible, the appropriate people to contact to reduce reticence and secure the support of crew chiefs, growers and camp managers.

Posters

Another simple yet effective public notification method is the use of posters placed in the camps, schools, food stamp offices, supermarkets, laundromats, Head Start centers, and any place in the community where migrant farmworkers might see them. Include both English and Spanish versions if needed. A bilingual poster "Food for Health" (PA-1268) is available from FNS for general outreach. The poster (1) briefly describes in both English and Spanish who is eligible for WIC and CSFP and what benefits these programs provide; (2) stresses the benefits of carrying proof of program certification from one area to another; and (3) contains space for a local WIC or CSFP agency to insert its name, address, and telephone number.

Public Media

Publicize the availability of the CSF and/or WIC program in the community in both English and Spanish or other appropriate language and use every type of media available. Homebase States should use all the media, such as television, radio, and newspapers, to notify potential participants of the programs to encourage migrants to apply for benefits both at home and when moving instream. When migrants are at their homebase, their lives are more stable and they have more time to find out about programs and services. That is when initial access to the program and delivery of nutrition education are most effective.

Influential Migrants

Another suggestion is to locate leaders in the migrant community itself and ask for their assistance. These local leaders can be a very effective conduit for program information.

State Agency Examples

Florida: From October to May the Florida WIC program serves approximately 69,000 migrants including Hispanics, Haitians, Vietnamese, and Laotians. Due to the long growing season and the diversity of crops, many migrants do not leave Florida but rather migrate within the State. However, Florida is the home-base State in the East Coast migrant stream. In January 1982, a severe freeze greatly damaged citrus and vegetable crops. This caused erratic movement of migrants throughout the State. WIC local agencies were faced with unexpected transfers. Because of this situation, Florida has created an effective system to stay abreast of the migrants in the State. A communications network of local, State, and national committees is utilized to improve outreach at the local and State level. This includes the 47 Florida Migrant and Rural Health Programs and 138 organizations and individuals which comprise a Farmworkers Communications Network. In addition, the Governor's Advisory Council on Farmworkers' Affairs established a Pesticide Committee. Activities conducted by this committee included collection of information from other States on pesticide safety and involvement in a pesticide safety workshop for farmworkers sponsored by the Migrant Health Unit of DHHS. A training session for local WIC agency personnel in matters related to migrant health was presented at the workshop. This session included procedures for performing income eligibility for migrants, identifying health problems particular to migrants, and problems in service to migrants, as well as techniques for reaching migrants.

Local agencies are provided an updated listing of network numbers and are encouraged to utilize their local resources, particularly interest groups, to locate migrants and improve services to that segment of the population. Public notification concerning WIC is carried out by several diverse efforts as follows:

- News releases in local newspapers, including foreign language and minority community newspapers.

- More emphasis is placed on the use of radio rather than the print media. When foreign language radio stations are available, local agencies utilize them for program announcements.

- Local agencies inform minority and "grassroots" organizations in writing of the availability of WIC benefits and the eligibility requirements.

- A pamphlet "How WIC Works" has been translated into Spanish, Creole, and Vietnamese and is made available to WIC applicants and potential eligibles.

- At the beginning of the migrant season in Hillsborough County, the WIC coordinator does a television show in Spanish which conveys nutritional information including information about WIC.

A major accomplishment in fiscal year 1982 was the screening of children enrolled in Migrant Day Care Centers throughout the State for WIC eligibility. This cooperative effort resulted in approximately 750 additional eligible migrant infants and children being placed on the program. An ongoing arrangement was also established whereby a new enrollee in any of the day care centers is automatically referred and screened for WIC eligibility. Florida uses bilingual or trilingual staffs/materials to reach non-English-speaking migrants in that State.

Maryland: Migrants are in the State from April until November. The duration of their residency in an area is usually 2 to 6 weeks. The Maryland State agency meets at appropriate times with local health providers and agencies such as the Delmarva (Delaware-Maryland-Virginia) Rural Ministries, Maryland Food Committee, Migrant and Seasonal Farmworkers of America, and the State Department of Education to evaluate the previous migrant season and to plan for the next migrant season. Referral network systems have been created to inform potential WIC participants of the program's services and benefits.

These systems are designed to avoid duplication of effort, improve service to migrants, and expedite the certification process. Spanish and Creole bilingual staffs and materials are used in outreach efforts. Where possible, agreements are negotiated to conduct eligibility determinations on the migrant camp premises.

North Carolina: Of the approximately 35,000 migrants who come to North Carolina, the WIC program serves about 5,900. The North Carolina WIC State agency works with a number of organizations serving migrants, including the Migrant and Seasonal Farmworkers Association, the Division of Health Services Migrant Health Program, and the Catholic Diocese. Sanitarians who inspect migrant camps for health reasons also serve as public awareness workers for the WIC program. WIC State agency staff attend workshops on migrant health offered by these groups. This includes an annual State migrant health conference.

The majority of migrants are Spanish/Mexican and American Blacks, with Haitians now comprising a growing portion (approximately 23 percent). An article on Haitians, their food habits, customs and culture, originally appearing in a Florida publication "The WIC Wire," has been sent to all local WIC agencies in North Carolina. Written materials are of limited usefulness as these Creole-speaking Haitian "entrants" are generally illiterate. Therefore, scripts (on cassette tapes) directed to potential participants have been developed and recorded in Creole.

North Carolina also finds that there is a need for educating the farmers regarding health care needs of migrants, services provided by health departments and other agencies, and the time involved in medical assessment and treatment of migrants.

North Dakota: Bilingual news releases describing the WIC program and announcing clinic sites are broadcast through radio and television stations during the migrant season. In addition, the Migrant Health Program and the North Dakota Rural Development Corporation play an active role in outreach for potential WIC participants.

Pennsylvania: The Bureau of Special Food Services (WIC) and the Bureau of Professional Health Services, Pennsylvania Department of Health, have an agreement which permits the Division of Migrant Health Programs to provide WIC services to instream migrant farmworkers. WIC services were provided to approximately 2,000 migrants during 1984.

Nurses from the Migrant Health Programs visit migrant camps and help provide WIC services, as well as other health services such as prenatal clinics, child clinics and dental clinics. A bilingual staff helps to screen migrants for the various health services offered. Picturegrams are used to assist migrants in the proper use of WIC food instruments (or checks).

Virginia: A large identifiable migrant population is concentrated on the Eastern Shore. Prior to 1981 the majority of this migrant population were Spanish. In 1981 Haitians became a part of the population. In this area the Virginia WIC program and the Delmarva Rural Ministry Migrant Project coordinate services to provide maximum quality health care and WIC services to migrants. A member of the Delmarva Rural Ministry Migrant Project serves on the Virginia WIC Advisory Committee and keeps the Virginia WIC State agency informed on where the current flow of migrants will be and what is specifically needed to better assist them in receiving benefits. Referrals are also coordinated through a joint effort of the Virginia WIC program, Eastern Shore Migrant Project, American Civil Liberties Union, Virginia Employment Commission, Migrant and Seasonal Farmworkers Association, Department of Social Services, and the local offices of the Virginia State Health Department.

West Virginia: West Virginia uses contractual agreements with two health agencies involving five counties to provide WIC services to migrants and seasonal farmworkers. The local health agencies make a special effort to recruit staff members with bilingual capabilities. The initial contact with a migrant in a migrant camp is through the crewleader, who is responsible for bringing migrants to the health clinics. These crewleaders receive instruction regarding the benefits of the WIC program and serve to publicize the program among the migrants. Bilingual posters are placed in each camp to further publicize WIC. Migrant health nurses also counsel migrants individually to explain the program and encourage participation.

Inter-County Health, Inc., which serves as a WIC local agency in Martinsburg, has produced a slide show in Creole and Spanish which shows all services available at that clinic site. It is shown by nurses and bilingual nutrition educators at migrant camps, as well as at the clinic.

Transportation

According to the evaluation of the FNS WIC Migrant Demonstration Project, 43 percent of all participants said transportation was a problem in getting to and from clinics as well as to retail grocery stores. An even higher percentage, 48.3 percent, of the nonparticipants interviewed said transportation was a barrier to participation.

The following table from the evaluation of the project shows the responses of participants when asked what type of transportation they used to attend the WIC clinic:

Type of Transportation	Percentage Response
Someone in my household drove me	63.2
Some other transportation (including walking)	11.0
Clinic arranged	7.1
Farmworkers organization arranged	2.2
Public transportation	1.1

Mobile clinics have proven highly successful in overcoming transportation barriers. Farmworkers and other organizations should be encouraged to use organization-owned vans and buses to provide transportation. Other community volunteers can also be a great asset in this effort.

State Agency Examples

California: All 26 migrant camps in California are located in counties with WIC programs. A number of local agencies (particularly Indian and other private non-profit agencies) utilize available transportation programs to accommodate the migrants or to coincide with the evening hours during which other clinic services are offered.

Colorado: Holding a food instrument issuance session at migrant camps is one approach that has helped to overcome migrant transportation problems.

Clinic Hours

Another important factor in reaching migrants is the scheduling of clinic hours. The evaluation of the FNS WIC Migrant Demonstration Project reported that the nonparticipants interviewed said that the hours offered by the WIC clinic were inconvenient.

Another significant finding was that 21 percent of the nonparticipants interviewed and 12.5 percent of the participants interviewed said they would have to miss work in order to keep clinic appointments. The following table shows the preferred clinic hours by WIC program participants:

Preferred Clinic Hours	Percentage Response
Morning	45.0
Evening	29.5
Afternoon	18.9

A recent study (Wilk, 1984) again confirmed that for migrants the lack of health care services or the inability to use available services is widespread. A special barrier was limited health clinic hours. Therefore, local agencies should be familiar with the growing patterns of crops in their areas, as well as be familiar with the kinds of situations, such as crop failures, labor disputes, and strikes, which affect migrant movements. This type of information may allow local agencies to schedule clinic hours around periods of a high influx of migrants. In addition, local agencies should be flexible in their clinic hours and possibly reschedule other appointments to take advantage of times when migrants are not working. Some clinics have also found that rainy days are often a popular time for migrants to apply or pick up food instruments. Migrants should be processed quickly and efficiently; they should not have long waiting periods once they reach the clinic. An important factor also is to try to coordinate hours with other service providers so that a migrant can obtain a variety of services in one trip.

State Agency Examples

Colorado: With funding provided through the State Department of Health/Migrant Health Program, the Colorado Migrant Council and the Colorado Department of Education/Title I Migrant School Program, 10 nutritionists and 1 nutrition aide were hired to assist in the delivery of WIC services to migrants. These additional seasonal personnel allow local agencies to provide outreach, special decentralized WIC clinics, and extended hours.

The clinics are often held in schools or churches, and are usually located at or near migrant camps. They may be held exclusively for WIC purposes or in conjunction with adult and well baby clinics. They are often operated in the evenings or on the weekends. The State agency suggests that if evening hours are established, personnel schedules at the clinic might be arranged so that employees work from 1:00 p.m. to 9:30 p.m., or take hours off in the afternoon and then work in the evening.

Washington: This WIC State agency serves approximately 25,000 migrants. In a number of local agencies migrants are seen at times ranging from 5:00 a.m. to 8:00 p.m., so as not to interfere with their daily work schedules.

Language Barrier

One of the most frequently mentioned problems in the delivery of health and special services to migrants is the language barrier. Both the WIC and CSFP regulations require that where a significant proportion of the population of the area served by a local agency is composed of non-English- or limited-English-speaking persons, bilingual staff or interpreters must be available. Such staff must be available to perform effective public notification, to explain the program, to explain how and where food instruments can be used, and to provide nutrition education. Local agencies are encouraged to hire bilingual paraprofessionals from the community during migrant seasons to serve as interpreters, translators, etc.

State Agency Examples

Florida: Migrants in this State include Haitians, Vietnamese, and Spanish-speaking persons. Bilingual nutritionists and numerous bilingual clerks are employed in local agencies serving significantly non-English-speaking populations. Those serving Haitian, Vietnamese, and Hispanic migrants have been successful in employing some trilingual staff to enhance delivery of services. Those local agencies who do not have bilingual staff have been successful in establishing arrangements with other health and/or social service agencies in their area who have interpreters available for their use. Additional efforts are cited under "Public Notification" and "Nutrition Education."

North Carolina: Often volunteer services (translators/interpreters) are provided by college students, church workers, and others from the community. When interpreters are not available, WIC staff use pictures, hand language, and body language. Scripts for WIC application/orientation have been developed and are currently being recorded in Creole for the Haitians. These scripts are on cassette tapes and are available to local agencies in North Carolina that serve migrants.

Tennessee: Local WIC agencies provide assistance in shopping if it is determined that the migrant might have difficulty in completing a voucher at a local grocery store because of communication problems.

Virginia: Special efforts include: training a WIC clerk (who also speaks Spanish fluently) to act as a Haitian interpreter and to translate nutrition education materials; and accompanying Haitians on a one-to-one basis to retail stores to show them WIC foods. General WIC program information, including participant agreements, has been translated into Creole, Korean, Laotian, Cambodian, and Vietnamese to accommodate migrants on the Eastern Shore.

Washington: A brochure describing the WIC program has been produced in English, Spanish, Laotian, Vietnamese, Cambodian, Chinese, and Korean.

Nutrition Education

The attendees at the 1979 WIC National State Directors' Meeting on Program Management reported that language problems, migrant attitudes, and limited time are the major barriers to effective nutrition education. The following suggestions were made by the group:

- Homebase States: It would be advantageous if homebase States provide more nutrition education during times when migrants are unemployed. During this time, migrant farmworkers have more time available and would be more receptive to nutrition education.

- Migrant Campsites: Local agencies should try to gain access to the camps, and build a rapport to create a climate in which nutrition education will be accepted.

- Length of Presentations: Nutrition education sessions should be designed to last no more than one-half hour. Such sessions might include onsite demonstrations in a home or camp kitchen.

- Subject Matter of Presentations: Nutrition education should be tied in with the supplemental foods being provided. Identify a few priority messages and stress them.

- Child Care: Such care should be provided so that participants can participate in nutrition education sessions without distraction.

According to Trotter (1984), providers of health and education services for migrants indicated a need for specific materials including those in the area of dental hygiene, hygiene, nutrition, early childhood development, adolescent pregnancy, infant care, lead toxicity, and substance abuse. Migrants indicated an interest in learning more about these health areas.

Research on the part of the health instructor (including visits to camps/homes to learn first-hand) may be necessary to determine popular foods, cooking techniques, recipes and meal patterns of migrants. As mentioned previously, nutrition education should reinforce the particular food package that is being prescribed.

The cultural eating patterns of various refugee groups can create a challenge to nutrition educators. As an example, the following is quoted from the April 1981 issue of the "WIC Wire" published by the Flordia WIC State agency: "Foods are classified into two groups by the Haitians: cold foods and hot foods (and it has nothing to do with the temperature of the food).

Cold foods are bread, orange juice, watermelon, grapefruit juice and cool water. Hot foods are most of the staples --lima beans, pork, tomatoes, plantains, malerugo and yucca roots (eaten like potatoes). In Haiti, pregnant women and those up to three months postpartum are in a 'hot time of life' and will eat no cold foods."

Therefore, not only is it necesary to be familiar with cultural/ethnic dietary patterns, but the health professional must also be aware of specific problems migrants may encounter. For example, migrants may have inadequate food preparation facilities. They may lack refrigeration or a sanitary water supply. When situations like these are present, the food package and nutrition education should be adjusted to fit the circumstances.

FNS Nutrition Education Materials for Migrants

The Nutrition Education Resource Guide: An Annotated Bibliography of Education Materials for the WIC and CSF Programs - is a bibliography of nutrition education materials developed by a variety of sources for use in WIC and CSFP. Materials for inclusion were selected on the basis of several criteria including content, reading level, and availability. The guide contains a Special Needs Cross Reference which points out those materials available in various languages -- Cambodian, French, Creole, Laotian, Portugese, and Spanish -- as well as for special groups such as handicapped children, Hispanic Americans, Native Americans, and Southeast Asians. Single copies are available free of charge to WIC and CSF program administrators from the Food and Nutrition Information Center (FNIC), Room 304, National Agricultural Library, Beltsville, Maryland 20705, telephone: (301) 344-3719. Many of the materials in the guide are available on a loan basis from FNIC.

The Idea Book (FNS-234) - shares nutrition education ideas and approaches from WIC programs around the country. Copies are available from the Supplemental Food Programs Division (SFPD), Food and Nutrition Service, USDA, Alexandria, Virginia 22302.

Promoting Breastfeeding: A Guide for Health Professionals Working in the WIC and CSF Programs (FNS-247) - provides a variety of ideas and successful approaches to help health providers be more effective in their efforts to promote breastfeeding among low-income women. Copies are available from the SFPD at the address cited previously.

How WIC Helps (PA-1198) - is a nutrition education brochure designed for pregnant and breastfeeding women participating in the WIC program. The brochure describes the WIC foods available; discusses the major nutrients provided by each of the foods and how the body uses these nutrients; and suggests the amounts of the four basic food groups that should be consumed each day. Also, recipes and snack ideas using various WIC foods are included. This publication is also available in Spanish (PA-1198S). Copies may be obtained from SFPD at the address cited previously.

Materials/Services Available from FNIC

In addition to the FNS materials cited, all WIC and CSF program administrators and nutritionists are encouraged to utilize materials and services available from FNIC. FNIC provides special services to FNS food assistance program personnel.

It is a specialized information center that provides information and educational materials on human nutrition, nutrition education, food consumption, food and nutrition programs, consumer protection (food), food science, food service, and educational methods and management. The books, journal articles, and audiovisuals in the FNIC collection have been developed by both public and private agencies and organizations, and are available for loan nationwide.

State Agency Examples

Colorado: This State has developed a variety of Spanish materials including a chart showing Mexican-American diet patterns with accompanying nutrition education ideas to tie in with this diet. This and other information on the delivery of services to migrants is included in the State's Procedure Manual. The following is an excerpt from the manual: "In large migrant families where there may not be enough plates, eating utensils, or chairs for all members of the family to eat together, people often help themselves to food from the kitchen stove at various times as they come in from the fields. Under these circumstances, supervision of children's eating practices and well-planned meals are difficult. Planning ahead for any meal takes considerable discipline, especially when frequent snacking is also a part of the dietary pattern. If snacks can be nutritious and considered as essential items in the diet, rather than auxiliary treats, the overall daily food intake can be improved."

Florida: This State has found that the language barrier resulting from the influx of refugee Vietnamese, Cubans, and Haitians, compounded by dialect variations of the Haitian population and illiteracy, has nullified the use of printed materials. Less than 10 percent of the Haitian population can read or write and many are totally unfamiliar with even seeing the written word. Therefore, communication has to be done through pictures. Bilingual or trilingual staff members are utilized to overcome the language barriers. These staff members have also found that, in addition to pictures, presenting the message in Creole in a simple song or verse form proves very effective. Hands-on demonstrations, such as taking the participant to the store and selecting the WIC foods, then going to the home to demonstrate how to prepare the foods, is invaluable in teaching these refugees. Florida has also produced a poster in Creole depicting the four food groups.

Maryland: This State generates and reviews periodically a monthly computer report identifying local agency participants who have and have not received required nutrition education contacts. State nutritionists then provide consultation to projects experiencing difficulty in delivering a minimum number of nutrition education contacts to participants. In addition, local agencies use the report to identify participants who need a contact.

New Jersey: A bilingual (English/Spanish) monthly newsletter, "WIC Ways," is published for WIC participants. A different local WIC agency is responsible for developing this newsletter each month on subjects such as prenatal weight gain and making baby foods. Each newsletter is submitted to the State WIC office for processing into a standard format. The State agency forwards a master copy to each local agency. One issue contained an article on Haitian food habits, customs, and culture.

North Carolina: The migrant population, consisting of Haitians, Southeast Asians, and Spanish/Mexicans, has a poor grasp of the English language and reading abilities are limited. The Haitian "entrants" are essentially illiterate. Therefore, educational materials using pictures are the most helpful, and if written are best at the low elementary level. When interpreters are not available, the WIC staff use pictures, food models, hand language, body language, and counting on fingers. Slide tapes and materials in Spanish are used, as well as a wide variety of nutrition education materials translated into Laotian, Vietamese, and Cambodian.

A manual entitled "Haitian Creole-English Phonetic Guide for Health Personnel," has been developed by the Migrant Health Program and is being used by WIC staffs. Each page of the manual has three columns: the first column designates the English phrase, the second column designates the Creole equivalent, and the third column is written phonetically to facilitate pronunciation for the English speaker. Questions and answers are given for the most common medical complaints in Creole and English. One section also addresses WIC eligibility. The following page provides an excerpt from the manual. A free copy of this manual is available upon request from:

Adult Health Services Section
Division of Health Services
Department of Human Resources
P.O. Box 2091
Raleigh, North Carolina 27602

QUESTIONS TO DETERMINE WIC ELIGIBILITY

What are you feeding your child?	Ki sa ou bay pitit la manje?	Kee sah oo bahy pee-teet lah maN-zhay?
What kind of milk does your child drink?	Ki kalite lèt ou bay bebe a?	Kee kah-lee-tay leht oo bahy bay-bay ah?
Have you received WIC coupons before?	Eske ou janm resevwa koupon WIC anvan?	Esh-kay oo jaNm ray-say-vwah koo-poN WIC aN-vaN?
How old is the baby?	Ki laj bebe a?	Kee lahzh bay-bay ah?
Are you breast feeding your baby?	Eske ou bay bebe a tete?	Ehs-kay oo bahy bay-bay ah tay-tay?
Is the water clean where you are living?	Eske dlo a prôp kote ou rete a?	Ehs-kay dloh ah prawp koh-tay oo ray-tay ah?
Do you boil the water before giving it to the child?	Eske ou bouyi dlo a anvan ou bay pitit lá bwè li?	Ehs-kay oo boo-yee dloh ah aN-vaN oo bahy pee-teet lah bweh lee?
Boil the water	Bouyi dlo a	Boo-yee dloh ah
Add one can of water to one can of (Similac, Enfamil, Isomil, Prosorbee)	Pou chak ti boit lèt (Similak, Anfamil, Isomil, Prozôbi) mete yon ti boit dlo	Poo shak tee bwaht leht (Similac, Enfamil, Isomil, Prosorbee) may-tay yoN tee bwaht dloh
How many bottles do you give the baby per day?	Konbyen bibon ou bay bebe a pa jou?	KoN-byeN bee-boN oo bahy bay-bay ah pah zhoo?
Do you give the baby water to drink?	Eske ou bay bebe a dlo pou li bwè?	Ehs-kay oo bahy bay-bay ah dloh poo lee bweh?
Do you give the baby juice to drink?	Eske ou bay bebe a ji pou li bwè?	Ehs-kay oo bahy bay-bay ah zhee poo lee bweh?

Excerpt from: "SAK PASE? A Haitian Creole English Phonetic Guide for Health Personnel"

Produced by: Morris Carolina Migrant and Refugee Health Program

Virginia: To assist all migrant participants in better understanding the WIC check, a replica of a WIC check, 21" x 9" on light weight poster board, is used with sample food containers which can be mounted on the check with velcro. Participants select appropriate foods to purchase using this educational tool. Written instructions on using WIC checks have been translated into Korean, Spanish, and Vietnamese. This State has also developed a variety of nutrition education publications in Cambodian, Haitian Creole, Korean, Laotian, Spanish, and Vietnamese.

Utah: This State has information produced by the American Dental Association on "Nursing Bottle Mouth" translated into Laotian, Cambodian, and Vietnamese.

Cultural Beliefs

Understanding the cultural beliefs, customs, and behaviors of various populations is an important aspect of serving migrants. Health professionals should be aware of the different values, as well as the health and diet beliefs, of the cultural groups they serve. They should also be aware of variations in communication styles -- both verbal and non-verbal (e.g., eye contact, body language, and formality) -- so that they use the proper strategies in communicating with these groups.

State Agency Examples

Florida: Information on refugee cultural beliefs and habits is disseminated to local agency staffs through the bi-monthly publication of the "WIC Wire." The following are excerpts from the "WIC Wire" on the Haitian culture:

WIC WIRE - April 1981

"In Haiti, there is no organized medical system. Therefore, medical theory is not understood by the Haitian population. The system of services in our health departments is very confusing to them. Medical services in Haiti are handled through or by the voodoo priest. Medicines consist of herbs and cactus or whatever else is available. All medicines are shared with family and friends. When the pain stops, they quit taking the medicine -- to them, the pain is cured. If the pain recurs, they start the medicine again...

"In Haiti every Haitian group has a voodoo priest. In Florida some of the Haitian groups have retained this philosophy and selected a priest out of their group that came over. The newly selected priest (or it could be one that came over with them) is your main contact person because his people go to him for advice on everything. They will not do anything disapproved by the priest. Since these participants would go to their priest for advice, you will find that you have to gain the confidence of the priest before participants will try new practices that you may recommend during counseling. Always try to compliment their system, whatever it is...

"Haitian families in South Florida have retained many of the same food patterns that they practiced in Haiti. Usually, the big meal is consumed at mid-day and it consists of rice, beans, meat and plantain. Breakfast is bread or cereal and/or banana and coffee. Supper may be cereal such as sweetened corn meal. Sunday is usually the time for chicken with macaroni, potato salad and other treats."

WIC WIRE - May 1982

"A major influence on the Haitians' attitude toward health care is the practice of voodoo. At times even Haitians who have been educated abroad may consult voodoo doctors. Unlike traditional Western medicine where the patient plays a passive role, voodoo requires that the patient be actively involved in his own treatment. This active involvement in medical treatment carries over into the Haitians' approach to their health care. Hazel Weidman (University of Miami Medical School, Department of Psychiatry) has found that Haitians in Miami believe that aspects of their life-style influence their health. The Haitians surveyed said that eating well, their personal hygiene and keeping regular hours were three aspects of their lives which could promote good health. This belief, coupled with the voodoo requirement that they be actively involved in their own treatment, can be a motivating factor in getting Haitians to follow medical advice and come to the clinic. Unfortunately, this same strong involvement with their personal health care often interferes with the prevention and treatment of disease in Haitians.

"Because the Haitians' initial approach to prevention and treatment of disease is often home diagnosis and home remedy, the clinic may not be the first place they go seeking medical care. For example, if a Haitian child sleepwalks or complains of stomach cramps, the child's mother may diagnose worms and use a home remedy of teas, leaves, roots or other substances to get rid of them. In Miami, some Haitian stores import and sell these special remedies to the Haitian population.

"If home remedies do not work, Haitians may next consult either a voodoo priest (a houngan) or a "leaf doctor" depending upon whether or not they believe their illness is due to supernatural or natural causes. Either of these "doctors" may recommend special remedies, rituals or foods to help Haitians recover from their illness. If all this fails, Haitians then may seek care from the Health Department, but they may not stop using the other remedies obtained from their folk healers or their family. It is recommended that Health Department staff ask Haitians about teas, purges and other "cures" which they may be taking concurrently with Western medications. The effects of these home remedies on the course of Haitian illnesses are still largely unknown.

"There is one exception to a delay in seeking care from Western physicians. If a Haitian child is seen as being very ill, some Haitian parents will first consult a clinic. Also, Haitians who are from a town or village in Haiti where physicians are available may consult a physician more readily than Haitians who are unfamiliar with Western medical practices.

"As stated previously, Haitians believe that disease is caused by either supernatural or natural causes. Supernatural illnesses occur because a curse is placed on the person. This curse may be the result of the individual having angered one of several possible supernatural forces. One reason these forces are angry could be that the Haitian failed to hold an annual feast for either his ancestors or special voodoo 'spirits.' They believe that one type of hypertension is due to the angry spirit of a dead person sitting on the person's neck. Because this illness is caused by supernatural forces, the person would consult only a voodoo priest for treatment.

"Although Haitians recognize that illness may be due to natural causes, they do not attribute the causes of their natural illnesses to the same factors as Americans would. Surveys of Haitians in the United States have shown that they feel that irregularities of the blood or its movement in the body are the most important causes of illness. Irregularities of the blood fall into several types: thick, thin, dirty, weak, dark or yellow. Haitians believe that thick blood can be the result of a severe fright or being the victim of injustice. With a scare, the patient's blood may move to his head causing headaches or partial loss of vision. They believe thin blood will cause pallor, and patients who have dark blood will probably die of their disease.

"Another belief is that irregularities or abnormal movement of milk in lactating women will lead to illness either in the women or their infants."

Minnesota: The following are excerpts from the final report of a WIC demonstration project carried out by the Minneapolis Health Department in conducting a model program to effectively serve Indochinese refugees:

"The Southeast Asian refugees are composed of various ethnic groups -- Vietnamese, Laotians, Hmong, and Cambodians. Lao and Hmong women observe a one-month diet restriction after the birth of an infant during which the only foods eaten are rice, boiled chicken, eggs, herbs, and hot broths. Vietnamese follow a similar pattern, but include pork as well as chicken. No fruits or vegetables, food of cold temperature, or foods perceived to be cooling to the body are eaten. Calcium, riboflavin, vitamin A, and ascorbic acid are low enough in the postpartum diet to be of concern if the woman is breastfeeding. The postpartum restrictions are related to the traditional belief that health is achieved by balancing hot and cold humoral influences. Since the body is believed to be in a cold state following the birth of an

infant, only foods that are hot in temperature or that are believed to make the body hot are consumed. Eating 'cold' foods during the postpartum period is believed to cause ulcers, rheumatism, and/or premature aging...

"Why the dietary restrictions of the postpartum period are so rigidly upheld while other advantageous cultural practices such as breastfeeding are being abandoned is not known. It is known, however, that elders and husbands are particularly adamant about continuation of traditional food patterns following delivery. To accept the advice of Western health professionals for postpartum diet over family recommendations is to undermine the strength of the family and traditional lines of authority...

"Also, all of these ethnic groups tended to overfeed with formula. There appeared to be no tendency to extend the supply of formula by overdiluting. Some tendency to supplement breastfeeding with sweetened condensed milk, sometimes used undiluted, is occasionally observed, which also contributed to obesity in infants. (Sweetened condensed milk was used to feed infants in Laos in the absence of mother's milk.) Also various cultural beliefs about infant feeding are being woven by the Hmong into a constantly changing mythology about infant formula. Minerals are thought to cause kidney damage in infants; water is associated with the transmission of disease. Thus, ready-to-feed formula is considered superior for infants, and iron-fortified formulas are viewed with suspicion. Although milk-based formula with iron was universally chosen by the Hmong parents at the start of the project, the realization that it contained iron caused many parents to later choose soy-based formula, which they erroneously believed did not contain iron. Nutrition counseling had to be modified somewhat to stress the positive, 'blood strengthening,' features of iron-fortified formula rather than the nutrient iron. Fear of minerals and contamination caused some parents to boil the can of concentrated formula before diluting it. In addition, formula feeding and breastfeeding are not considered compatible by the Hmong. Women believe that they must either totally breastfeed or totally bottle feed. This belief prevents many women who want to attend school from practicing breastfeeding."

Referrals/ Coordination

The initial delivery of and continuation of WIC and CSF program service to migrants is dependent on an active referral and coordination process with other agencies serving migrants. Use of the following resources will strengthen this process:

Verification of Certification (VOC) Cards

Foremost in the process of ensuring continuous WIC and CSF program service to migrant participants is the VOC card, a mechanism initiated during the FNS Migrant Demonstration Project in 1978. Although the VOC card is available to any participant who plans to relocate, it is designed primarily for use by migrant farmworkers. Issuance of a VOC card guarantees that the participant will receive continuous benefits for the duration of his

or her certification period within the funding limitations of the local agency. The issuance of VOC cards supports the WIC legislative mandate that a person's certification remain valid until the end of the certification period when the person moves from one area to another in which the program operates. Local agencies are required to accept VOC cards as proof of both income and nutritional risk eligibility for program benefits.

When migrant farmworkers arrive at a new local agency and have not previously been certified for the WIC program, the local agency should be prepared to perform certification, issue VOC cards, and provide benefits to migrants who qualify for the program, if funds are available. Another situation which local agencies should be prepared to meet involves cases where migrants previously received WIC program benefits but did not receive a card prior to leaving their home State or lost their card en route. The new local agency should make every attempt to contact the last certifying local agency, if known, and verify the pertinent information. If these attempts are unsuccessful or impossible, the certification procedure at the new local agency should be followed.

As stated above, the continuity of benefits to migrant farmworkers throughout the certification period is dependent, to a large degree, on the issuance of a VOC card. The certification system can break down when:

- migrants are not provided a VOC card;

- there is no record of food package issuance on an issued VOC card;

- the VOC card contains insufficient information about nutritional risk conditions and health information; and

- the VOC card is incomplete and is missing data such as the original certification date or the expiration date.

Although the VOC card speeds up enrollment, instream local agency personnel are responsible for explaining the differences in food delivery systems from one State to another, prescribing a food package, and explaining the differences in services between local agencies. All these services are delayed when VOC cards are incomplete and instream local agencies must spend time contacting the originating agency for the missing information.

Camera-ready copy of an FNS developed VOC card has been provided to all WIC and CSF State agencies. The State agency may use either the FNS VOC card or its own card. However, program regulations require that all such State-developed cards contain the following information:

- name of participant;

- date certification was performed and date certification expires;

- date income eligibility was last determined;

- nutritional risk of the participant;

- signature and printed or typed name of the certifying local agency official;

- name and address of the certifying local agency; and

- identification number for the participant or some other means of accountability.

DHHS Migrant Health Program

In July 1980, a "Joint Statement of Cooperation" was issued by the USDA Supplemental Food Programs and the DHHS Migrant Health Program. The joint statement was developed to identify means of integration of services and express commitment of USDA and DHHS toward inter-program cooperation at the regional, State, and local level.

The authorizing legislation for the Migrant Health Program is the Migrant Health Act enacted in September 1962 by Public Law 87-692, which added Section 310 to the Public Health Service (PHS) Act. Public Law 94-63 (July 1975) substituted Section 319 for Section 310 and added amendments defining eligible services, population and service arrangements in detail. Public Law 95-626 extended Section 319 as Section 329 for two years, effective November 1979. Subsequent reauthorizing legislation has not amended the program purpose or requirements.

The major goals are to:

- provide access to high quality, comprehensive primary care health services for migrants and their families which meet the unique health and social needs of a mobile population;

- ensure that centers are well managed systems of care with strong governance, administrative, and clinical components;

- evaluate delivery models of care which are appropriate to the size of the migrant population, the availability of health resources in the area where migrants work and live, and the time migrants remain in the area; and

- garner public and private resources for migrant populations through inter-project cooperative arrangements with other programs serving migrants.

Migrant health centers provide comprehensive primary health care to migrant and seasonal farmworkers and their families. Programs are linked or integrated with hospital services and other health and social services existing within the area. The level of activity is related to the length of time the migrant

population is in the service area and the availability and accessibility of health resources. These factors determine whether a project will be a year-round, full-time, multi-disciplinary primary health care delivery model; a seasonal or temporary (1-6 months) physician and/or nurse model with specialty referral; or a seasonal program which brokers service with local health providers on a contractual arrangement.

A migrant or seasonal farmworker is an individual whose principal employment within the last 24 months is in agriculture on a seasonal basis. A migratory farmworker establishes a temporary abode for purposes of such employment. The major patterns of migratory travel are referred to as "migratory streams." Some migrants travel a few hundred miles while others may travel more than a thousand miles as they follow the crops north in the spring and return south in the fall. Access to care for this group is therefore difficult because of their lifestyle, language and cultural differences, and economic status. In addition, most States consider migrants temporary residents, thus rendering them ineligible for Medicaid.

Migrant health centers, either through their employed staff or through contracts or cooperative arrangments with other public or private entities, provide the following services:

- services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;

- diagnostic laboratory and radiology services;

- preventive health services, including children's eye and ear examinations, perinatal services, well child services, and family planning services;

- emergency medical services;

- transportation services as necessary;

- preventive dental services;

- pharmaceutical services;

- supplemental health services: as appropriate for support of primary health services, hospital services, home health services, extended care facilities, rehabilitative services, mental health services, dental services, ambulatory surgical services, and health education services;

- environmental health services: detection and alleviation of unhealthful conditions associated with water supply, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, accident prevention including excessive pesticide exposure, housing and other factors; and

- a hospital program -- initiated in 1974 to provide inpatient hospital services to migrants in selected projects with no other means of obtaining inpatient care. It operates through financial arrangements using two mechanisms: (1) Blue Cross/Blue Shield (BC/BS) which allows enrolled migrants and their dependents to chose their own provider of care who accepts the BC/BS card both at homebase and upstream locations, and (2) Health Care Finance Administration which allows centers to negotiate with local hospitals for their patients' hospital care.

The 122 migrant health centers operate about 378 clinics located in over 300 rural areas in 35 States and Puerto Rico. These centers serve more than 450,000 migrant and seasonal farmworkers.

A 1985 Migrant Health Centers Directory, which also contains a list of DHHS regional offices, is included in the resource packet accompanying this handbook. It was funded by DHHS, and compiled by the National Migrant Referral Project (NMRP), Inc., in Austin, Texas. This directory is a comprehensive listing of all DHHS migrant health grantees and their satellite clinics. It also contains a separate listing of migrant health centers which operate perinatal centers, as well as a listing of each State health department's central administrative office to provide an additional health resource, such as to locate a county health department for immunization information.

WIC and CSF programs should invite representatives from migrant health projects to attend and participate in conferences and training sessions to facilitate closer coordination. Consideration may be given to joint outreach or nutrition education efforts.

For additional information, contact the appropriate PHS Regional Office or the Migrant Health Program, 5600 Fishers Lane, Room 7A-55, Rockville, Maryland 20857.

National Migrant Referral Project, Inc. and Migrant Student Record Transfer System

The NMRP is the principle organization that facilitates the accessing and updating of medical information of student records maintained under the national Migrant Student Record Transfer System (MSRTS).

Fiscal year 1985 activities for the NMRP include:

Facilitating continuity of care through the transfer and updating of medical information providing:

- linkages to the MSRTS;

- a manual referral system; and

- an initiation of a patient toll-free telephone referral service.

Monitoring leading health conditions and tracking those which have significant impact through:

- publishing Clinical Medical Alert System (Med Alert); and

- establishing/maintaining a morbidity reporting system.

Identifying, collecting, and distributing a range of health data and other educational information through:

- maintenance of a publication/reporting library;

- a supply of audiovisual materials; and

- migrant health brochures.

Serving as marketing/distributing agent through:

- publishing a directory of migrant health centers;

- editing a migrant health newsletter (Newsline); and

- facilitating poster competition at migrant health conferences.

Conducting provider orientation for new medical staff of migrant health centers.

The following describes the MSRTS: "As migrant families move into and across the United States and Puerto Rico in search of agricultural or fishing employment, their children are often placed in many schools during the year. Their transiency poses problems for school systems in providing continuous educational experiences for migratory children. A communications network, known as the MSRTS, offers a solution to the problem of program discontinuity. The MSRTS, a nationwide communications network, helps school personnel by collecting and storing health and academic records and forwarding them upon request. By providing background data, continuity of health and educational services is a realistic goal for migratory children.

"Before MSRTS was established in 1969, educators working with migrant children were generally unable to obtain and exchange accurate, complete, up-to-date records on children due to their rapid mobility. Typically, children would arrive without records from previously attended schools. Consequently, improper grade placement, constant retesting, and duplication of services often resulted. MSRTS helped rectify these problems by providing data services to migrant education personnel nationwide so that appropriate services can be planned for the Nation's migrant children." (MSRTS Brochure)

In December 1979, DHHS and the Department of Education entered into an agreement to coordinate their efforts of extending health care to migrant children. One aspect of this coordination of services occurs through the use of the MSRTS by the migrant health clinics to foster continuity of health care for the migrant child.

The MSRTS is a nationwide communications network connected to a central computer in Little Rock, Arkansas. It contains the educational and medical records of more than 600,000 migrant children. Once the child has entered the school setting, relevant academic data such as participation in special programs, special interests, or results of academic tests are forwarded to the Little Rock Center to become a part of his/her record. In addition, results of physical exams, inoculations, dental services, and other health data are recorded. Two major benefits are afforded by the forwarding of health data to subsequent schools of attendance. These are: 1) needless duplication of health services is avoided and 2) critical problems are brought to the immediate attention of school health personnel." (MSRTS Brochure)

As the migrant health clinics access the computer system, the student's medical information is gradually increased beyond a simple school record. Through the use of a Health Exception Report, any authorized health provider can retrieve and/or enter a condensed report of key medical conditions, treatments, and contact information for follow-up care. This report is generated by the computer from the entire body of information in the patient's medical file.

To expedite the implementation of the Migrant Health/Migrant Education linkage, NMPR staff have developed a telephone procedure and expanded communication capabilities by adding a toll-free number and more terminals to their Austin, Texas data exchange center which is connected to the MSRTS central computer in Little Rock. By following this procedure, migrant health clinics have access to the medical and dental records of migrant children.

For more information on the Migrant Health Program's use of the computer-based medical records, contact:

Dan Cardenas, Executive Director
National Migrant Referral Project
2512 South IH-35, Suite 220
Austin, Texas 78704
Toll-free telephone numbers are: Texas: 1-800-252-9446
Elsewhere: 1-800-531-5120

For further information on the MSRTS, contact:

W. "Joe" Miller, Director
Migrant Services
Arkansas Department of Education
Archford Education Building
Little Rock, Arkansas 72001
Telephone: 501-371-7754

East Coast Migrant Health Project

The East Coast Migrant Health Project (ECMHP) is sponsored by the National Migrant Worker Council, Inc. The project is funded by DHHS. The ECMHP offers a combination of outreach service and referral in health maintenance, health education, and continuity in health care delivery, as the migrant/seasonal farmworkers travel up and down the east coast.

The project contracts already existing health providers along the east coast to make sure health services are available, accessible, and acceptable to the migrating population. The ECMHP staff reach out not only to provide immediate care, but to search for long-term solutions for the provider and the recipient. In addition, ECMHP volunteers also supplement existing staff.

The project provides skilled health and allied health professionals, as well as those with social service and community skills. Outreach is the primary objective and method by which ECMHP staff link primary health care of the clinic/Public Health Department to the migrant/seasonal farmworker camps and the rural poor communities. The project is primarily interested in health professionals of all levels with particular emphasis on nurse practitioners, community and public health nurses, licensed practical nurses, and other health professionals with specialty certificates.

The project, likewise, recruits persons in the allied health fields, such as medical social workers, nutritionists, health educators, and physician assistants. Equal emphasis is given to recruitment of community social service workers.

States served include: New York, New Jersey, North Carolina, South Carolina, and Florida. (ECMPH Brochure)

For further information contact:

East Coast Migrant Health Project
Suite 623
1234 Massachusetts Avenue, NW
Washington, D.C. 20005
(202) 347-7377

National Advisory Council On Migrant Health

This council serves as adviser/consultant and makes recommendations to the Secretary of the DHHS and Administrator of Health Resources and Services Administration concerning the organization, operation, selection, and funding of migrant health centers and other entities under the Public Health Service Act.

The council consists of 15 members selected by the Secretary, 12 of whom are members of governing boards of migrant health centers and are familiar with health care delivery to this farmworker population. The remaining three members are individuals trained in the medical sciences or health administration.

The council meetings are held annually and are open to the public unless determined otherwise by the Secretary. Members deliberate and make written recommendations to the Secretary.

An annual report is submitted in December each year and contains a roster of members, dates, and places of meetings, and a summary of activities and recommendations of the council.

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Overview of the Supplemental Food Programs

The establishment of both the CSF and WIC programs was prompted by studies showing that women who suffer from malnutrition during pregnancy risk permanent physical and mental damage to their unborn children. This critical stage of development for a child continues through the early years. When pregnant women, infants, and young children are undernourished during critical periods of growth and development, there can be mental retardation, learning disabilities, impairment to physical growth and development, and infant mortalities due to low birth weight.

CSF provides nutritious commodity foods at no cost to supplement the diets of low-income pregnant, postpartum and breastfeeding women, infants, and children under six years of age, who are vulnerable to malnutrition. Nutrition education is offered as a part of the program, with a special emphasis on the nutritional needs of the individual.

USDA donates commodity foods to the State agencies, such as the departments of health, social services, education, or agriculture, for distribution to participants and provides funds to State and local agencies to cover certain administrative costs. USDA pays for the initial processing and packaging of the food and transporting it to the State agency. State distributing agencies are then responsible for storing the food and distributing it to local agencies. Local agencies provide the foods to participants. The flexible design of the CSFP allows State and local agencies to administer the program in a manner tailored to the community's needs and resources. Community involvement in the CSFP takes many forms, ranging from supplying volunteer drivers to providing warehouse space.

The WIC program provides specific nutritious supplemental foods and nutrition education as an adjunct to good health care at no cost to a clientele similar to that served by the CSFP. In WIC, children are eligible up to age five. WIC participants are eligible low-income persons who are determined by competent professionals to be at nutritional risk. Federal funds are available to participating State health departments or comparable State agencies. Indian tribes, bands, groups, or their authorized representatives recognized by the Bureau of Indian Affairs, U.S. Department of the Interior, or the appropriate area office of the Indian Health Service, U.S. Department of Health and Human Services, may also act as State agencies. These agencies distribute funds to the participating local agencies. The funds pay for supplemental foods for participants and pay allowable administrative costs, including those of nutrition education.

WIC food packages are designed to supplement participants' diets but not to provide for total dietary needs. The supplemental foods are high in protein, calcium, iron, and vitamins A and C, which are nutrients most lacking in the diets of pregnant, breastfeeding, and postpartum women, infants, and children at nutritional risk. In addition, the foods have been selected because they are readily accepted by program participants, commercially available nationwide, economical in cost, and administratively manageable.

Nutrition education is available to all adult WIC participants, to parents or caretakers of infant and children participants, and, whenever possible, to the children who participate. Its goals are to teach the relationship between proper nutrition and good health, to help the individual at nutritonal risk develop better food habits, and to prevent nutrition-related problems by showing participants how to best use their supplemental and other foods. The WIC program also encourages breastfeeding and counsels pregnant women on its nutritional advantages.

CSFP Historical Review

Between 1962 and 1968, a series of meetings was held between the Department of Agriculture (USDA) and the Department of Health, Education, and Welfare (now the Department of Health and Human Services-DHHS). The purpose was to discuss the problem of infants and pregnant and breastfeeding women from low-income families who lacked adequate foods, were vulnerable to malnutrition, and would benefit from more effective use of the donated commodity foods program. Further, in 1968, a Citizens' Board of Inquiry into Hunger and Malnutrition in the United States recommended supplementing the diets of these infants and women. As a result, in May 1968, USDA agreed to establish a Supplemental Food Program for this target population. The program was officially established by administrative action in 1969 as an extension of the Commodity Needy Family Program. The first authority to expend funds for a supplemental feeding program appeared in the Agricultural Appropriation Act for 1969 (Public Law 90-463) approved August 8, 1968.

The Supplemental Food Program was thus designed to provide supplemental food packages in the form of USDA-donated commodities for pregnant and breastfeeding women and infants. It was recognized that while the Food Stamp Program did provide substantial food assistance to low-income families, many high-risk individuals were not eligible for the program, or were eligible but in need of additional food due to their nutritional risk condition.

In 1973, Congress appropriated funds to purchase additional commodities to continue the program. Public Law 95-113, enacted September 29, 1977, authorized the continuation of the program through fiscal year 1981. (Section 5 of this law also changed the name of the program to the "Commodity Supplemental Food Program.") The Agriculture and Food Act of 1981 (Public Law 97-98) reauthorized the program through fiscal year 1985.

Currently, the program operates in 13 States through 28 local agencies and serves approximately 131,000 participants. It is administered by State agencies such as the departments of health, social services, education, or agriculture. A local agency may be a public or private nonprofit agency that provides a service to low-income persons.

The program also serves as a link to health care in that local agencies must provide health care or advise participants where they can obtain it. At a minimum, participants must be told of the importance of health care.

To be eligible for the CSFP, women, children, and infant applicants must: (1) live in an area where the CSFP is operating; (2) meet the income standards for benefits under existing Federal, State, or local food, health, or welfare programs for low-income persons; and (3) at the State agency's discretion, be determined to be at nutritional risk by a physician or staff person at the local agency.

After applicants are certified, they receive either food packages or vouchers entitling them to pick up the food at the local distribution center every month or every other month. There are food packages for different categories of participants and the foods offered include infant formula and cereal, farina, juice, egg mix, nonfat dry and evaporated milk, dehydrated potatoes, peanut butter or dry beans, canned meat/poultry, and canned fruits/vegetables. Special bonus items of surplus cheese, butter, rice, honey, and raisins are also being made available at this time. These items are not, however, part of the regular authorized food package.

The CSFP food packages do not provide a complete diet, but rather supplemental foods that are good sources of the nutrients lacking in the diets of the target population. Breastfeeding women receive a package containing additional food to meet their extra nutritional needs.

In 1977, Public Law 95-113 authorized the use of Federal funds for program administration. Initially, Federal funds were only used to purchase and transport the foods to a State-designated warehouse. The responsibility for administrative costs was borne by sponsoring local agencies with assistance from public and private sources. This led to strong community support and involvement, which continues to exist today in some areas.

The use of commodities in the CSFP plays an important role in the support of the United States' farm sector since most of the foods are purchased under price-support and surplus-removal legislation.

WIC Historical Review

The WIC program was created in 1972 by Public Law 92-433, in response to Congressional concern that the special needs of women and young children were still not being met by existing

programs. WIC began as a 2-year pilot program to provide supplemental foods to low-income pregnant and breastfeeding women, infants, and children up to age four, who were at nutritional risk. In November 1973, Public Law 93-150 continued WIC to fiscal year 1975 by authorizing $40 million. This law also allowed Indian tribes, bands, or groups recognized by the Department of the Interior, and the Indian Health Service of the Department of Health, Education, and Welfare, to operate as State agencies. Public Law 93-326 later increased the funding for fiscal year 1975 to $100 million.

Because of the program's high growth rate and its continued support by States, local agencies, and other interest groups, Congress in October 1975 passed Public Law 94-105, which authorized $250 million for each of fiscal years 1976, 1977, and 1978. This law also changed the age limit to allow children to participate until their fifth birthday; increased the State agencies' administrative allowance to 20 percent of program funds; authorized expenditure of administrative funds for nutrition education and startup costs; and established the National Advisory Council on Maternal, Infant, and Fetal Nutrition.

Public Law 95-627, enacted on November 19, 1978, further extended the authorization for WIC through fiscal year 1982. It required formulas for the distribution of funds; required the Secretary to establish an income eligibility standard for the WIC program; and also required an outreach program. This law authorized $550 million for fiscal year 1979 with further authorized increases in fiscal years 1980 and 1981, and $950 million for fiscal year 1982. Public Law 97-35 changed the authorized funding up to $1.017 billion for fiscal year 1982, to $1.060 billion for fiscal year 1983 and up to $1.126 billion for fiscal year 1984. (Actual appropriations for fiscal year 1982 were $904.32 million plus the use of unobligated fiscal year 1981 funds.) Public Law 96-499 extended the program through fiscal year 1984. The program operated in fiscal year 1985 with funds provided by a Continuing Resolution, Public Law 98-473.

Currently WIC operates through State health departments in 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. Additionally, 33 Indian tribal bands and organizations serve as State agencies. Approximately 1,600 local agencies serve about 3.2 million participants through some 7,100 clinic sites.

Eligibility for participation in the WIC program is based on three major factors. First, a participant must be categorically eligible either by being a pregnant or postpartum woman, an infant, or a child under the age of five. Second, a participant must have a low income. Third, a participant must be certified by a health or nutrition professional as having a nutritional risk condition. "Nutritional risk" is a term used to indicate such health problems as anemia, abnormal weight gain during pregnancy, a history of high-risk pregnancies, low birth weight, stunted growth, overweight or underweight, or an inadequate dietary pattern.

Because WIC operates as an adjunct to good health care, participants are encouraged to take advantage of the health care that is available to them. WIC and the health community work hand-in-hand to ensure better health and nutritional status for a vulnerable population.

Regulations issued in November 1980 and republished in a new final rule on February 13, 1985, designate WIC food packages that are designed for different categories of participants. These packages contain foods that are good sources of nutrients most likely to be lacking in the WIC population's diet -- protein, iron, calcium, and vitamins A and C. The packages are based on infants' developmental needs and pediatricians' recommendations on infant feeding; correspond to recommended eating patterns for preschool children; meet the additional requirements of pregnant and breastfeeding women; and also encourage breastfeeding.

Infants through 3 months of age receive iron-fortified formula. Older infants (4 through 12 months) receive formula, iron-fortified infant cereal, and fruit juice high in vitamin C. Women and children receive fortified milk and/or cheese, eggs, hot or cold cereals high in iron, fruit and vegetable juices high in vitamin C, and either peanut butter, dry beans, or dry peas. WIC provides breastfeeding women with a food package to meet their extra nutritional needs. Women and children with special dietary needs may receive a package containing cereal, juice, and special formula for the treatment of medical conditions such as metabolic disorders, inborn errors of amino acid metabolism, gastrointestinal disorders, malabsorption syndromes, and certain allergies.

In most States, WIC participants receive food vouchers to purchase the supplemental foods at a local grocery store. These vouchers are "food-specific," meaning they can be used only for the foods prescribed by the health or nutrition professional at the local agency. In a few other areas, the foods are delivered to a participant's home, or the participant picks up foods from a warehouse. A combination of these delivery systems also exists in some States. Each State agency can design a food delivery system to meet its needs.

APPENDIX II

HISTORICAL REVIEW OF WIC AND CSFP EFFORTS FOR DELIVERY OF SERVICES TO MIGRANTS

In response to the unique needs of the migrant population, special provisions have been implemented in the WIC and CSF programs through the years to ensure the provision of continous program benefits to migrant farmworkers. Legislative provisions and special program efforts, such as coordination with migrant service organizations, special funding allocations and reporting requirements, State plan requirements, emphasis in management evaluations, publications, and demonstration projects, are discussed below:

Provisions - WIC Program

Legislative Provisions

- Public Law 92-433 (September 1972) created the WIC program and stated that eligibility for participation should be based, in part, on residence within the area served by the local agency. This residency requirement presented somewhat of a barrier to the migrant population.

- Public Law 94-105 (October 1975) revised the eligibility criteria to read "participants shall be residents of areas or members of populations...". Migrant families fall into the latter category. This revision was designed to aid in improving the accessibility of WIC program benefits to migrant farmworkers by removing the legislative requirement that all WIC program participants be residents of a local agency's service area.

- Public Law 95-627 (November 10, 1978) includes several provisions directly concerned with migrants, as follows:

  - Section 17(f)(1) State Plan of Program Operation and Administration - Migrants are mentioned in two of the subparagraphs on State plan requirements:

    Subparagraph (F) requires States to provide "...a description of the methods that will be used to meet the special nutrition education needs of migrants..."

    Subparagraph (G) requires States to describe "plans to provide program benefits...to eligible migrants..."

  - Section 17(f)(3) Migrant Participation Procedures - This paragraph requires USDA to establish procedures which will, to the maximum extent feasible, allow migrants to continue program participation when they move from one area to another. It also mandates that "Each State agency shall be responsible for administering the program for migrant populations within its jurisdiction." Clearly, this wording emphasizes the concept that States, regardless of the migrant's homebase, are obligated to offer full and expedient service to migrants.

- Section 17(f)(8) Program Publicity - Farmworker organizations are listed as an example of the type of organization to which States must distribute information concerning the availability of program benefits, including the eligibility criteria and the location of local agencies operating the program.

- Section 17(f)(14) Bilingual Requirements - Both program administration materials and nutrition education materials and instructions are required to be provided in appropriate foreign languages when a substantial number of families speak a language other than English.

- Section 17(g) Evaluations and Pilot Projects - The "special needs of migrants" were designated as a primary area of concern for the funds set aside for WIC evaluations and pilot projects.

- Section 17(j) Migrant Report - The law requires the Secretary of Agriculture to prepare a report each year describing plans to ensure as much as possible continuation of benefits to migrants as they move between States. The report is to be made available to the National Advisory Council on Maternal, Infant, and Fetal Nutrition.

- Section 17(k)(1) Advisory Council Membership - The law designates one member of the Council to be "a representative of an organization serving migrants."

Regulatory Provisions

Following are provisions in the WIC regulations that pertain to migrant farmworkers. In some instances, additional clarification is also provided for the reader.

o July 1979 Final WIC Regulations - These regulations published pursuant to Public Law 95-627, improved the accessibility of the WIC program to migrant farmworkers and enhanced the quality of WIC program services. The regulatory provisions specifically designed to aid migrant farmworkers are as follows:

- Section 246.4 State Agency Plan of Program Operation and Administration

  The Affirmative Action Plan - (List of areas in State based on health and income statistics ranked in priority order according to need in order to direct program funds toward those persons at greatest nutritional risk.)

  "The Affirmative Action Plan will not be approved by FNS unless Indian and migrant farmworker populations that exist within the jurisdiction of the State agency are given consideration."

  In the development of its Affirmative Action Plan, a State agency must give consideration to migrant farmworker populations. To assure that migrants receive proper consideration, a State agency must use the best statistical infor-

mation available for migrant farmworkers. The Affirmative Action Plan should include an estimation of the number of migrant farmworkers who will be provided WIC services during the fiscal year by local agency and the source of the data. States that do not have Indian or migrant populations that are potentially eligible for the WIC program should include a statement to that effect in the plan.

The State plan must also discuss its plans and procedures to provide program benefits to eligible migrant farmworkers and Indians to ensure that eligible migrant farmworkers may, to the maximum extent feasible, continue to receive program benefits when they enter the State agency's jurisdiction subsequent to original certification in another program jurisdiction.

- Section 246.7 Certification

Processing Standards - "...members of migrant farmworker households who soon plan to leave the jurisdiction of the local agency shall be notified of their eligibility or ineligibility within 10 days of the date of the first request for program benefits."

Eligible transient applicants must receive benefits when a local agency is not at maximum caseload within 10 days as opposed to the 20-day limit for most other applicants. The participant must either receive food instruments upon certification, or have supplemental foods delivered within 10 days of notification of eligibility.

Verification of Certification (VOC) Cards - "Each State agency shall ensure issuance of a verification of certification form to every participant who is a member of a family in which there is a migrant farmworker..." The State agency shall require the local agencies under its jurisdiction to accept verification of certification from participants, including migrant farmworker participants, who have been participating in the program in another local agency within or outside the jurisdiction of the State agency. The verification of certification is valid until the certification period expires, and shall be accepted as proof of eligibility for program benefits. However, if the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all waiting applicants regardless of the priority of their nutritional risk criteria."

VOC cards help migrants continue participation in the program despite change in locality, by assuring continuity of service wherever possible.

Residency Restrictions - "The State agency may determine a service area for any local agency, and may require that an applicant reside within the service area. However, the State agency may not use length of residency as an eligibility requirement..."

The residency provision contains a protection for transient applicants against being penalized through denial of benefits for not living in the area for a specified amount of time.

- Section 246.9 Nutrition Education

"Nutrition education shall be considered to be a benefit of the program, and shall be provided at no cost to the participant. Nutrition education shall be designed to be easily understood by individual participants, and it shall bear a practical relationship to their nutritional needs, household situations, and cultural preferences including information on how to select food for themselves and their families."

- Section 246.22 Nondiscrimination

"...no person shall, on the grounds of race, color or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under the program."

- Section 246.22(b) Bilingual Information

"Where a significant proportion of the population of the area served by a local agency is composed of non-English or limited English speaking persons who speak the same language, the State agency shall take action to ensure that program information, except certification forms, is provided to such persons in the appropriate language orally and in writing. The State agency shall ensure that there are bilingual staff members or interpreters available to serve these persons. The State agency shall ensure that all rights and responsibilities listed on the certification form are read to these applicants in the appropriate language."

This provision requires the availability of interpreters at the local agency when necessary, and the reading and explanation of certification forms in the language each participant understands.

- Section 246.23 Fair Hearings

"The State agency shall provide a hearing procedure through which any individual may appeal a State or local agency action which results in the individual's denial of participation, suspension, or termination from the program."

The participant must be notified of the right to a fair hearing upon certification and at any time that benefits are to be terminated. If for any reason the participant is to be dropped from the program, notice must be given of the impending termination 15 days in advance. An applicant who is determined to be ineligible can appeal that decision through a hearing. An individual need only make a request for a hearing (of the local or State agency) to start the appeals process.

- January 1981 - WIC Income Eligibility Regulations

  - Section 246.4 State Plan of Program Operation and Administration

    "...the definition of a migrant farmworker shall be included in the plan."

    To make the distinction between migrant participants and other persons, local agencies must be able to identify migrants.

  - Section 246.7 Certification

    "If an instream migrant farmworker participant needs to be certified again because the participant's verification of certification card has expired, the participant shall be deemed to satisfy the State agency's income standard. Any determination that a migrant has met the income standard, either in the migrant's home base area before the migrant has entered the stream for a particular agricultural season, or in an instream area during the agricultural season, shall satisfy the income criteria for that migrant participant in any State for any subsequent certification while the migrant is instream during that agricultural season. (This procedure shall not apply to participants whose verification of certification cards have expired if the participants are not instream migrant farmworkers.)"

    Based on legislation, program regulations require State agencies to establish an income standard no lower than 100 percent and no higher than 185 percent of the Office of Management and Budget poverty guidelines. Due to the range, income standards may vary from State to State. As migrants travel from one area to another continuous income redeterminations would be costly to local agencies while proving burdensome and occasionally inequitable to migrants.

- February 1985 Final WIC Regulations - These regulations added a definition for migrant farmworker.

  - Section 246.2 Definitions

    "Migrant farmworker" means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.

- Section 246.4 State Plan

Requirements include:

Plans "to provide Program benefits to eligible migrant farmworkers and their families, and to Indians."

Plans "for informing eligible persons of the availability of Program benefits, including the eligibility criteria for participation and the location of local agencies operating in the Program. Such information shall be publicly announced by the State agency and by the local agencies at least annually. Such information shall also be distributed to offices and organizations that deal with significant numbers of potentially eligible persons, including health and medical organizations, hospitals and clinics, welfare and unemployment offices, social service agencies, farmworker organizations, Indian tribal organizations, and religious and community organizations in low income areas."

"...methods that will be used to meet the special nutrition education needs of migrant farmworkers and their families and Indians."

- Section 246.7 Certification of Participants

Residency Restrictions - "All State agencies may determine a service area for any local agency, and may require that an applicant reside within the service area. However, the State agency may not use length of residency as an eligibility requirement."

Income - "Instream migrant farmworkers and their family members with expired Verification of Certification cards shall be declared to satisfy the State agency's income standard; provided, however, that the income of that instream migrant farmworker family is determined at least once every 12 months. Any determination that members of an instream migrant farmworker family have met the income standard, either in the migrant's home base area before the migrant has entered the stream for a particular agricultural season, or in an instream area during the agricultural season, shall satisfy the income criteria in any State for any subsequent certification while the migrant is instream during the 12-month period following the determination."

Processing Standards - "Special nutritional risk applicants shall be notified of their eligibility or ineligibility within 10 days of the date of the first request for Program benefits..." "The State agency shall establish criteria for identifying categories of persons at special nutritional risk who require expedited services. At a

minimum, however, these categories shall include pregnant women eligible as Priority I participants, and migrant farmworkers and their family members who soon plan to leave the jurisdiction of the local agency."

Verification of Certification Cards - "Each State agency shall ensure issuance of a Verification of Certification card to every participant who is a member of a family in which there is a migrant farmworker or any other participant who is likely to be relocating during the certification period. Certifying local agencies shall ensure that Verification of Certification cards are fully completed.

"The State agency shall require the receiving local agency to accept Verification of Certification cards from participants, including participants who are migrant farmworkers or members of their families, who have been participating in the Program in another local agency within or outside of the jurisdiction of the State agency. A person with a valid Verification of Certification card shall not be denied participation in the receiving State because the person does not meet that State's particular eligibility criteria.

"The Verification of Certification card is valid until the certification period expires, and shall be accepted as proof of eligibility for Program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all waiting applicants.

"The Verification of Certification card shall include the name of the participant, the date the certification was performed, the date income eligibility was last determined, the nutritional risk condition of the participant, the date the certification period expires, the signature and printed or typed name of the certifying local agency official, the name and address of the certifying local agency and an identification number or some other means of accountability. The Verification of Certification card shall be uniform throughout the jurisdiction of the State agency."

- Section 246.8 Nondiscrimination

Civil Rights Requirements - "...no person shall, on the grounds of race, color, national origin, age, sex or handicap, be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination under the Program."

Non-English Materials - "Where a significant number or proportion of the population eligible to be served needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the State agency shall take reasonable steps considering the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to required program information except certification forms which are used only by local agency staff. The State agency shall also ensure that all rights and responsibilities listed on the certification form are read to these applicants in the appropriate language."

- Section 246.9 Fair Hearing Procedures for Participants

"The State agency shall provide a hearing procedure through which any individual may appeal a State or local agency action which results in the individual's denial of participation or disqualification from the Program."

- Section 246.11 Nutrition Education

"Nutrition education shall be considered a benefit of the Program, and shall be made available at no cost to the participant. Nutrition education shall be designed to be easily understood by participants, and it shall bear a practical relationship to participant nutritional needs, household situations, and cultural preferences including information on how to select food for themselves and their families. Nutrition education shall be thoroughly integrated into participant health care plans, the delivery of supplemental foods, and other Program operations."

Funding Allocations

The WIC Migrant Demonstration Project in 1978 (described elsewhere in this handbook) laid the groundwork for improving services to migrant families. To assist State agencies in this effort FNS provided 25 State agencies with special funds for fiscal year 1979 for the purpose of serving migrants. These funds were granted with the intent that they would be regarded as a permanent increase in a State agency's authorized funding level; they were also protected from the reallocation procedure. As a result, $2,723,186 (updated from the 1980 Migrant Report because one State did not spend all of the funds requested) in program funds were allocated to these States for the purpose of serving migrants. The funds were allocated by FNS based on the following information provided by the State agencies involved:

- plans for opening or expanding programs in migrant areas, including the name and address of the local agency and the area served by the agency;

- anticipated migrant caseload, by month, and a description of how the State served these estimates;

- food package costs; and

- estimated numbers of migrants currently being served or who were served the previous year at the local agencies.

In fiscal year 1980 a total of $4,864,185 ($3,896,080 food and $968,105 administrative) was allocated to 29 State agencies to provide services to migrants. The allocation of these funds enabled WIC State agencies to reach a cumulative total of 254,682 migrants in fiscal year 1980, which represents a 147.3 percent increase over the fiscal year 1979 cumulative migrant participation total.

For fiscal year 1981, a total of $4,980,877 ($3,997,651 food and $983,226 administrative) was allocated to 29 State agencies to serve migrants and this special allocation became a part of these States' basic fiscal year 1981 funding grants. In fiscal year 1981, 261,502 migrants were reached. This is a 3 percent increase over fiscal year 1980. Approximately 205,062 migrants were reached in the first 9 months of fiscal year 1982. This is an 11 percent increase over the same period of time in fiscal year 1981.

Commencing with fiscal year 1982, it was determined that States were successfully serving their migrant populations and that it was no longer necessary to earmark funds for migrants. Therefore, under subsequent funding methodology USDA believed State agencies should manage funds to ensure maximum utilization as well as continued service to migrants.

Reporting Forms

FNS uses a computerized WIC Funding and Participation Report (WI-129) that provides on a monthly basis the current migrant participation in each State agency. This data source helps to assist program administrators in monitoring and targeting WIC services to migrant farmworkers.

Provisions - CSFP

Regulatory Provisions

Following are provisions in CSFP regulations that relate to migrant farmworkers:

o January 1981 Final CSFP Regulations - Improved the accessibility of the CSF program to migrant farmworkers with the following special provisions:

- Section 247.7 Certification

Residency Requirement - "The State agency may determine a service area for any local agency, and may require that an applicant be residing within the service area at the time of application to be eligible for the program. However, the State agency may not impose any durational or fixed residency requirements. For example, migrant and seasonal farmworkers entering a CSFP service area shall be considered as meeting the residency requirement."

- food package costs; and

- estimated numbers of migrants currently being served or who were served the previous year at the local agencies.

In fiscal year 1980 a total of $4,864,185 ($3,896,080 food and $968,105 administrative) was allocated to 29 State agencies to provide services to migrants. The allocation of these funds enabled WIC State agencies to reach a cumulative total of 254,682 migrants in fiscal year 1980, which represents a 147.3 percent increase over the fiscal year 1979 cumulative migrant participation total.

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- Section 247.8 Nutrition Education

"Nutrition education shall be thoroughly integrated into Program operations. Nutrition education shall be designed to be easily understood by individual participants and shall bear a practical relationship to their nutritional needs and household situations."

Nutrition education is to be used "within the context of ethnic, cultural and geographic preferences. Consideration should also be given to tailoring nutrition education to meet any limitations experienced by groups of participants, such as lack of running water, lack of electricity, and limited cooking or refrigeration facilities."

- Section 247.19 Nondiscrimination

"...no person shall, on the grounds of race, color or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under the Program."

This nondiscrimination policy must be adhered to in the making of any decision that affects an applicant or participant in the CSF program.

Non-English Materials and Staff - "Where a significant proportion of the population of the area served by a local agency is composed of non-English or limited English speaking persons who speak the same language, the State agency shall take action to ensure that Program information, except certification forms, is provided to such persons in the appropriate language orally and in writing. The State agency shall ensure that there are bilingual staff members or interpreters available to serve these persons."

This provision requires the availability of interpreters at the local agency when necessary, and the reading and explanation of certification forms in the language each participant understands.

- Section 247.20 Fair Hearing Procedures

"The State agency shall provide a hearing procedure through which any individual may appeal a State or local agency action which results in the denial or termination of benefits to the individual."

A participant must be notified of the right to a fair hearing upon certification and at any time that benefits are to be terminated. If for any reason a participant is to be dropped from the program, notice must be given of the impending termination 15 days in advance. An applicant who is determined to be ineligible can appeal that decision through a hearing. An individual must make a request for a hearing (of the local or State agency) to start the appeals process.

National Advisory Council on Maternal, Infant, and Fetal Nutrition

This council is mandated by Public Law 95-627. Its function is to make a continuing study of the operation of WIC and related programs, such as the CSFP, and to determine areas of program administration and operation that need improvement. The law mandates that the council report its recommendations for administrative and legislative changes to the President and Congress on a biennial basis. The council is composed of 21 members and includes a representative of an organization serving migrants.

The following are excerpts from the council's 1980, 1982, and 1984 reports on improving services to migrants. In each case, the council's recommendation, as well as USDA's response, is provided for the reader.

- Recommendation (1980 Report): "States with migrant populations must be required to make special efforts to reach these people in areas served by the programs. The council believes these States should explain in their State Plans how they will provide SFP services to migrants. State Plans that do not outline adequate activity should not be approved by USDA. State Plans should:

  a) Provide for funding local agencies that want to serve migrants even though another agency already provides SFP services in that area. States should give priority to migrant health clinics funded by the Public Health Service and to organizations, governed by farmworkers, that provide health services.

  b) Require local agencies that serve non-English-speaking migrants to hire bilingual personnel."

  Action Taken by USDA (1982 Report): "The WIC State Agency Plan of Program Operation and Administration is required by regulations to stress providing services to migrants as follows:

  Definition of Migrant - The State Plan must include the definition of migrant farmworkers used by the State agency.

  Affirmative Action Plan - Each State agency must have a current Affirmative Action Plan (AAP) in order to guide selection of new or expanded local agencies. State agencies must strive to direct the use of available funds toward the neediest people in unserved or underserved areas. In developing its AAP, a State agency must consider migrant farmworker populations. To assure that migrants receive proper consideration, a State agency should use the best statistical information available for migrant farmworkers. The AAP must include an estimate of

the number of migrant farmworkers who will receive WIC services during the fiscal year by each local agency and the source of the data. States that do not have migrant populations that are potentially eligible for the WIC Program must include a statement to that effect in the plan.

Outreach - The State Plan must describe action that the State and local agencies will take:

- to establish and expand outreach activities;
- to publicize the availability of program benefits, eligibility criteria, and the location of local agencies operating the program where migrants are present in significant number; and
- to coordinate with other agencies that concentrate on service to migrants.

Outreach techniques used for migrants might include outreach in migrant camps by bilingual staff members or volunteers, explaining eligibility requirements and program benefits, and certification and voucher issuance from mobile units in migrant camps.

Certification - Each State agency is required to issue written verification of certification to migrant farmworker participants or other participants likely to relocate. This certification must be accepted by local agencies operating WIC or CSFP within each State or in other States so that the person can continue to participate in the new location. The State Plan must include a copy of the Verification of Certification (VOC) card to be used.

Any special arrangements to serve migrants, such as evening clinic hours or issuance of food instruments at migrant camps, must also be included in the State Plan.

The State agency may find it helpful to have a special segment in the Procedure Manual (State agency's guidance to local agencies which also becomes part of the State Plan) on services to migrants. This could include special instructions on use of the VOC card, issuance of food or food instruments to migrant farmworkers, and procedures to follow if there is a waiting list.

Nutrition Education

Public Law 95-627 requires that nutrition education be considered as a benefit of the WIC Program and be provided to participants at no cost. To ensure implementation of this requirement, the State Plan must describe how nutrition education will be provided to participants during the fiscal year. This includes the procedures the State will use to meet the special nutrition education needs of migrant farmworkers.

Civil Rights

States must have special provisions for areas with a significant proportion of non-English or limited-English-speaking people. The State agency must ensure that the local agency provides bilingual program information orally and in writing. They must also have bilingual staff members available to serve these people. The State Plan must describe the availability of such bilingual staff members.

In addition, USDA awarded two grants for demonstration projects specifically relating to migrants and the WIC Program. The purpose of one project was to: (1) identify outreach procedures to increase migrant participation in the WIC Program; (2) recommend ways to overcome barriers and to ensure continuous migrant participation; and (3) recommend nutrition education methods that can best reach the migrant population. The project ran from January 1, 1980, through December 30, 1980. Results of the project are being made available to all State agencies.

The second project evaluated the effect of the WIC Program on migrant farmworkers and on their use of the health services in rural areas. The project operated from October 1, 1979, to September 30, 1981. Results of this project, too, are being provided to all State agencies operating the WIC Program."

- Recommendation (1980 Report): "USDA should continue to provide special allocations for States with large numbers of migrants and to monitor the services for migrants. USDA should develop a method to ensure that States with large numbers of migrants either apply for a special allocation or justify failing to do so."

  Action Taken by USDA (1982 Report): "In Fiscal Year 1980 special funds in the amount of $4,864,185 ($3,896,080 food and $968,105 administrative) were allocated to 29 State agencies to provide services to migrants. The allocation of these special funds enabled WIC State agencies to reach a cumulative total of 254,682 migrants in Fiscal Year 1980. This figure represented a 147.3 percent increase over the Fiscal Year 1979 total for cumulative migrant participation.

  "For Fiscal Year 1981, a total of $4,980,877 ($3,997,651 food and $983,226 administrative) was allocated to 29 State agencies to serve migrants and this special allocation became a part of the State's basic Fiscal Year 1981 funding grant. In Fiscal Year 1981, 261,502 migrants were reached. This is a 3 percent increase over Fiscal Year 1980. Approximately 205,062 migrants were reached in the first 9 months of Fiscal Year 1982. This is an 11 percent increase over the same period of time in Fiscal Year 1981.

"In Fiscal Year 1982, these States' basic funding grants did not include special funds earmarked for migrants. However, funding was based on Fiscal Year 1981 participation, including migrants served. With this funding methodology, USDA believed State agencies should manage funds to ensure maximum use and continued service to migrants within funding constraints."

- Recommendation (1980 Report): "Congress should legislate a definition of the term 'migrant' that would be used nationwide. States would then have to use this definition to provide an accurate count of the migrants working in their jurisdictions."

  Action Taken by USDA (1982 Report): "A National WIC and CSFP State Directors' Meeting on Program Management was held in Albuquerque, New Mexico in December 1979. A major issue discussed during four workshops conducted on providing WIC and CSFP services to migrants was whether the definition of the term 'migrant' should be adopted. State Directors were divided on the question of whether USDA should establish one standard definition for WIC and CSFP purposes. Those extremely opposed to the idea thought that to do so would reduce State flexibility. For this reason, the WIC Program Income Eligibility Regulations issued in January 1981 require that each State agency in its State Plan of Program Operation and Administration define 'migrant.' The State must then use this definition to provide an accurate count of the migrants working in its jurisdiction."

- Concern (1982 Report): "Since migrants are an especially needy segment of the population, as many eligible migrants as possible should receive WIC and CSFP benefits. Therefore, the issue of whether a national definition of the term 'migrant' should be established for the purpose of these programs is of concern to the Council. In its last report to Congress, the Council recommended that the Congress should legislate a definition of the term 'migrant' that could be used nationwide. Federal agencies and States use a variety of definitions to establish eligibility criteria for migrants and this results in inequities and confusion.

  "In recognition that migrants need special assistance, Public Law 95-627 (1978) requires USDA to establish procedures under which eligible migrants may continue to participate in the WIC Program to the maximum extent feasible as they move among States. In response to this legislative mandate the WIC Program regulations contain:

  1) a provision that migrants must receive expedited services, i.e., eligible migrant applicants must receive benefits within 10 days as opposed to the 20-day limit for most applicants;

2) a provision that if a locality in which an eligible migrant transfers has a waiting list, he/she must be placed on the list ahead of all nonmigrant applicants regardless of the priority of his/her nutritional risk; and

3) a provision which protects migrants from being penalized through denial of benefits for not living in an area for a specified time.

"To ensure continuation of benefits (supplemental foods and nutrition education) special provisions have also been made by FNS for WIC participants transferring into an area where only CSFP exists. In such instances CSFP regulations require that their local agencies accept verification of certification forms from the WIC participants, which allows automatic transfer to CSFP. If the receiving CSFP local agency has waiting lists for participation, the transferring participant must be placed on the list ahead of all waiting applicants.

"However, at a National WIC and CSFP State Directors' Meeting on Program Management held in Fiscal Year 1980, workshop attendees were divided as to whether USDA should establish a national definition for 'migrants.' Therefore, USDA has not defined the term 'migrant' in order to allow States maximum flexibility in serving this segment of the population. Particularly, USDA did not wish to establish a definition that might unintentionally exclude important groups from the migrant category. Since migrants are considered a particularly needy segment of the population, as many eligible people as possible of this population should receive program benefits, as is the intent of Public Law 95-627.

"The current Council members reexamined this issue at their July 1982 meeting, since certain program areas continue to request a national definition. The Council could not, however, come to a consensus as to whether the 1980 recommendation to Congress should be reaffirmed. A vote on the issue revealed that a small majority favor a national definition. Those members who do favor a national definition suggested that the DHHS definition of 'migrant agricultural worker' be adopted. The definition is as follows:

> 'An individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who has established for the purpose of such employment a temporary abode.'

"The difference of opinion among Council members indicates that this issue is not easily resolved. It may be advantageous for USDA to again survey the WIC State agencies to determine their preference as to whether a standard definition should be established, and, if so, what it should be. USDA might also consider raising the issue in future proposed rules and ask for comments and suggestions for wording."

Action Taken by USDA (1984 Report): "In response to the Council's request to raise the issue in proposed rules and to survey WIC State agencies, USDA did so in proposed WIC rules published in July 1983. Eight definitions were reviewed before proposing one similar to that used by DHHS.

"Almost all commenters expressed support for a national definition; however, about one-fourth recommended minor modifications to the one proposed to make it identical to that used by DHHS..."

New WIC rules reflecting these comments were published February 13, 1985.

Demonstration Projects

Migrant Demonstration Project - 1978 - In January 1978, FNS funded a Migrant Demonstration Project to test methods of improving the delivery of the WIC program benefits to migrant farmworkers. The project had three objectives:

- provide funds to implement or expand WIC projects where there was a large migrant population;

- track participants as they moved from Texas into other States within the midcontinent migrant stream and back to Texas; and

- experiment with innovative program methods to serve migrants.

The project, which ran from January through December 1978, was conducted in the midcontinent stream. Participating local agencies were required to maintain monthly participation logs, provide nutrition education in English or Spanish, and, when necessary, complete a standard VOC card for each participant. FNS developed the VOC card to overcome the chronic problem of maintaining continuity of services for migrants who previously had to be certified at each new location. The VOC card provided the new local agency with verification of eligibility and information on the nutritional status and nutrition education needs of the participant.

Three other components were also developed by FNS for use in this project:

- a migrant demonstration Project Guide which described the requirements for participation in the project, the tracking system, and the use of nutrition education modules;

- a WIC Program Directory of Local Agencies to assist State and local agencies to identify sites where migrants could obtain WIC benefits and other health services. Participants received a directory when they were issued a VOC card; and

- uniform nutrition education materials in modular form for use in all participating agencies. Information in the modules was based upon ethnic patterns and unique characteristics of the migrant family and was in both Spanish and English. The 11 modules were designed so that each was a complete nutrition education lesson on a different subject such as vitamin A, protein, calcium, etc. Therefore, local agencies could present the modules either sequentially or according to the specific nutrition education needs of each migrant participant. Since the VOC card contained information on which modules had been presented at previous locations, repetition was avoided.

An evaluation was also built into the project to assess:

- the effectiveness of the administrative structure in promoting continuity of benefits for participants;

- the reduction of real and perceived barriers to participation; and

- the provision of WIC supplemental foods, and nutrition education services to migrants in the region of the pilot project.

Conclusions of the evaluation showed that the project did assist in providing better services to the migrants. It pointed out that the major barriers to participation were lack of knowledge about the program, lack of transportation to the clinic, inconvenient clinic hours, and language barriers. As a result, program changes, including regulatory requirements and special funding allocations, were initiated to better serve WIC migrant participants nationwide.

Other Demonstration Project Grants - WIC legislation, Public Law 95-627, enacted November 1978, set aside one-half of 1 percent of WIC program funds, not to exceed $3 million, each fiscal year for the purpose of evaluating program performance, evaluating health benefits, and administering pilot (demonstration) projects. As a result, in both 1979 and 1980, a variety of small-scale projects, designed to develop and test creative approaches to improve the delivery of WIC program benefits and program administration, were awarded grants. There were 2 grants that specifically involved migrants. The following are executive summaries of these 2 projects:

TITLE: WIC Migrant Evaluation Project - 1979

GRANTEE: National Child Nutrition Project
New Brunswick, New Jersey

ABSTRACT

This project was designed to evaluate WIC program delivery systems to determine their effectiveness in reaching and serving migrant farmworkers, and to make recommendations that would both increase participation of and improve services for this popula-

tion. A collection of data was obtained from State and local WIC programs; from a sample of migrant, seasonal farmworker, rural, and Hispanic women in four selected States; and from local social service and health agencies, schools, and other Federal food programs serving these women and their children. The data was analyzed to determine the effects of WIC program policies and procedures on the participation of migrant farmworkers and to determine how best to promote inter-agency cooperation.

DESCRIPTION OF PROJECT

Target Population: The target population included 42 State and 188 local WIC agencies serving migrants; a sample of 263 women in 4 States; and a sample of 130 local social and health agencies, schools, and other Federal programs located in the areas serving this sample of women.

Objectives: Specific objectives for the project were to recommend:

1. Outreach methods which are most effective in reaching the migrant population.

2. Procedures to overcome barriers, such as transportation problems and hours of operation.

3. Procedures to ensure continuous participation.

4. Nutrition education methods which are most acceptable to migrant participants.

Methodology: A mail questionnaire was used in a national survey to obtain data from a sample of 42 State and 188 local WIC programs. The purpose was to analyze the effects of WIC program policies and procedures on the participation of migrant farmworkers, and to obtain information on which to base recommendations for program improvements. Data was also obtained through interviews with a sample of women, which included 125 migrant farmworkers, 62 Hispanics, 32 seasonal farmworkers, and 44 who lived in rural areas in New Jersey, New York, Pennsylvania, and West Virginia. These women were either participating in WIC or were eligible to participate.

Information from the interviews with the sample women was used to determine the effectiveness of different methods being used to reach and serve migrants, barriers to program participation, and the most acceptable methods of nutrition education. Data were collected on both participants and non-participants in order to distinguish any differences between these two populations which may help to explain the lack of participation. The information was also used to separate out the effects of doing seasonal farmwork, living in a rural area, and being of Hispanic descent from the migratory lifestyle. This information was then used to determine what recommendations would prove most effective in ensuring continuous WIC participation for migrants as they travel throughout the stream.

A community agency survey was conducted to obtain data from 130 local social services and health agencies and schools to anaylze the extent of cooperation between these institutions and the WIC program. The purpose was to determine how best to promote inter-agency cooperation to increase the WIC program's effectiveness in reaching and serving migrant farmworkers.

Timeframe: The project was conducted from January 1, 1980 through December 30, 1980; the data were actually collected between March and November 1980.

Materials Developed or Used: The following forms were developed and used:

1. Participant Questionnaire
2. State WIC Program Questionnaire
3. Local WIC Program Questionnaire
4. Participant Interview Form
5. Non-participant Interview Form
6. Form for Interviewer's Observations
7. Community Agency Questionnaire
8. Federal Food Program Questionnaire
9. School Questionnaire

Summary of Results: The following is a summary of the recommendations offered to USDA and to State and local WIC programs on ways to improve WIC program services for migrant farmworkers:

1. USDA must adopt a specific definition for a migrant farmworker, preferably one that would include a 2-year time limit after the date of last migration.

2. Standardized VOC cards should be used by all States with instructions and training available on their issuance and use.

3. USDA should provide special migrant grants and should closely monitor the services offered under these grants.

4. A manual on migrant participation and resources should be available to all State and local WIC programs. It should include a definition of a migrant farmworker, standardized statistical reporting procedures, and the identification of reliable sources of information. It also should contain suggestions for overcoming barriers to migrant participation, such as effective outreach methods, suggested transportation arrangements, clinic hours, and available nutrition education materials.

5. Priority in WIC program sponsorship should be given to programs already serving migrant farmworkers, such as migrant health and child care programs. In addition, WIC programs should establish a close coordination with other local programs serving this population.

Final Report:

The project's final report, submitted November 1981, contains several recommendations on how USDA can improve WIC services for migrants. These recommendations include: adopting a standard definition for the term migrant, increasing funding to serve migrants, and making available a migrant handbook for program administrators.

TITLE: Evaluation of Health Services Utilization in Rural Areas and Among Migrant Farmworkers - 1979

GRANTEE: Michigan Department of Public Health
Lansing, Michigan

ABSTRACT

The purpose of this study was to evaluate how various factors associated with continuity of care influence one dimension of patient behavior -- referral completion rates. Health care delivery can be organized to provide continuity of care in several ways. Continuity can be achieved through one provider who is responsible for a comprehensive number of services that the patient utilized sequentially. It can also be achieved by providing one location for services or a medical record which is shared by programs serving a common population. Continuity of care is considered desirable in that it is presumed to result in greater patient and provider satisfaction. Limited research has been done to evaluate which aspects of continuity of care influence patient satisfaction the most.

The study attempted to measure the impact of several related characteristics such as convenience of hours, distance to services, and time lapse between referrals and appointments. These variables were studied within a migrant population and within a rural population served through local public health departments or Rural Health Initiatives (RHI). No attempt was made to draw comparisons between results for these groups.

DESCRIPTION OF PROJECT

Target Population: The target population for the project included migrant farmworkers and rural populations. The estimated number of migrant farmworkers employed in Michigan is approximately 40,000 workers and family members. According to 1970 U.S. Census data, approximately 2,300,000 persons live in rural areas in Michigan.

Objectives: The objectives of the project were to:

1. Determine the effect of the WIC program on the utilization of other health services by WIC participants and their family members, such as: primary care; secondary care (referral to specialists); and health department programs, including family planning, Early and Periodic Screening, Diagnosis and Treatment, child health clinics, immunization clinics, maternal and infant care programs, and environmental health programs.

2. Determine the effect variables found in various models in WIC service delivery have on the utilization of the WIC program and the utilization of other health services.

Methodology: The study considered various clinic characteristics in each of three subdivisions of the Michigan public health care system (i.e., migrant health centers, local health departments, and RHI/local health departments). In this way, differences in the ethnicity and mobility of the target populations, the variety of referral definitions, and clinic flow could all be considered. The study consisted of three components -- a Migrant Health Clinic Study, a Local Health Department Study, and an RHI Study.

The Migrant Health Clinic Study was designed to be a stratified random sample of clusters and referrals. The clusters consisted of the referrals of a specified type which would be obtained from a WIC clinic during the time span of the study. The 24 strata used were depicted by cross classifications of the following characteristics:

1. Location of other health services referred to in relation to the location of a WIC clinic;

2. Date the service referred to was offered relative to the WIC visit (i.e., time interval);

3. Integration status of staff who initiated the referral;

4. Type of staff who initiated the referral; and

5. Type of service to which referral was made.

Follow-up on unkept referrals was considered the most critical aspect of the effort. By calling the participant at home or asking them at their next coupon pick-up visit, staff questioned participants as to why they did not complete a referral.

Logistic regression analysis for dichotomous variables was employed in the Migrant Clinic component of the study. It examined both the combined and separate contributions to the variation in referral completion rates attributable to the five characteristics cited above. Chi-square analysis was also used to examine the association of some of the characteristics with completion rates.

The Local Health Department Study was designed to ensure that the influence on referral completion rates of time and location of WIC and other health service clinics, the integration status of staff and the type of service referred to could be studied. As in the Migrant Clinic Study component, the study was designed to be a stratified random sample of clusters of referrals as described in the migrant study. Twelve strata were depicted by cross-classifications of the following four characteristics:

1. Location of other health services referred to in relation to the location of WIC clinic;

2. Date the service referred to was offered relative to the WIC visit;

3. Integration status of staff who initiated the referral; and

4. Type of service to which referral was made.

Logistic regression analysis for dichotomous variables was also employed in this component of the study. Loglinear analysis of multiway contingency tables and chi-square analysis were also used to examine the association of some of the characteristics with completion rates.

The Rural Health Initiative Study component was designed to assess the possible relationship between the location and concurrent utilization of WIC and RHI clinics. It was also designed to examine the potential influence of location, type of provider agency referred to and type of service referred to on referral rates, referral completion rates, and distance referred among the client population of selected WIC clinics in local health departments.

WIC sites were selected which might generate a substantial number of health referrals in general and at least some referrals to RHI clinics in particular. Also, to measure the effect of distance between WIC and RHI sites on the referral process, WIC clinics were sought which were located on-site with RHI clinics and off-site within varying distances up to 23 miles from the RHI clinics. Sampling was not incorporated into the site selection process because few clinics were available which could meet the criteria for volume of potential referrals and location.

Summary of Results: The final report was submitted in August 1981. Study results indicated some different outcomes than anticipated. These outcomes are summarized below:

1. Total number of referrals were lower than expected.

2. Clinic schedules within local health departments could change drastically within a 2-month span, often due to budget and staffing constraints. Scheduling in the migrant setting remained fairly constant because of the seasonal nature of the delivery system.

3. When other key characteristics were taken into account, the date of service referred to relative to the WIC visit was a significant factor in relation to referral completion rates in both the migrant and local health department study components. As expected, same-day referrals showed higher completion rates than did different-day referrals.

4. In the local health departments, location was significantly related to referral completion rates, but contrary to expectations, off-site referral completion rates exceeded those for on-site referrals.

5. Integrating laboratory results and staff did not produce significantly higher referral completion rates than those where these characteristics were not integrated.

6. Distance referred for off-site referrals was not found to be significantly related to referral completion rates.

7. When the effects of time, location and staffing factors were controlled, referral completion rates did not differ by type of service referred to in the migrant or local health department components. In the RHI clinic component, referrals to various types of primary care (e.g., child care, crippled children screening, etc.) were completed at a higher rate than referrals to immunizations or family planning.

8. Referrals from local health department WIC clinics to Rural Health Initiatives were occurring in very low volume regardless of proximity.

National Association of Farmworker Organizations Telephone Hotline

In 1980 the National Association of Farmworker Organizations (NAFO) established a "Farmworker Information and Referral Hotline" to provide information, support, referral, and assistance to any farmworker living, traveling, and working across the nation. SFPD agreed to assist NAFO with this hotline.

Hotline telephone specialists knew and understood the problems faced daily by farmworkers, as well as the resources which were available to farmworkers. The hotline was accessible to any farmworker each day by dialing a specified toll-free number. The hotline specialists assisted farmworkers in many areas and provided information regarding available resources. If the hot-

line specialists received any inquiry regarding the supplemental food programs and they were unable to provide an answer, they made a referral to the national office of the supplemental food programs. The following procedure was adhered to:

- The hotline specialists would call one of two designated SFPD staff persons with the migrant's name, location, phone number, and the nature of the question or problem.

- The information was then given to another appropriate staff person with Regional responsibility for the area from which the migrant telephoned. If necessary, the staff person would call the migrant back immediately to obtain more information and to provide as many answers as possible. Due to the transient working patterns of the migrant population, the staff person could not always contact the original caller. Therefore, the staff person was directed to contact a relative, friend, or employer of that person.

- If additional information was needed to respond to the inquiry or complaint (from the Regional Office, State or local agency), the migrant was so informed and assured that every attempt would be made to resolve the problem and that the migrant would be recontacted if necessary.

- Bilingual staff handled calls from migrants who spoke only Spanish.

This project was carried out for approximately 6 months and was considered successful. Other agencies serving migrants may find it beneficial to establish a hot-line service.

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